United States Court of Appeals

for the Second Circuit

JOINT APPENDIX

76-7295

United States Court of Appeals

FOR THE SECOND CIRCUIT

FOR THE SECOND CIRCUIT

CARL A. BEAZER, *et al.*,
Plaintiffs-Appellees-Cross-Appellants,

—against—

NEW YORK CITY TRANSIT AUTHORITY, *et al.*,
Defendants-Appellants-Cross-Appellees.

UNITED STATES COURT OF APPEALS
FILED
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SECOND CIRCUIT

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

JOINT APPENDIX

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CARL A. BEAZER, et al

v 72 Civ 5307

NEW YORK CITY TRANSIT AUTHORITY

January 31, 1975

Trial Resumed

* * *

KENNETH JULIUS JENKINS,

called as a witness by defendants Transit Authority, being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. DUNN:

Q By whom, Mr. Jenkins, are you employed?

A New York City Transit Authority.

Q And in what capacity?

A Director of Personnel Administration.

Q How long have you occupied that position?

A Since July 1st of last year.

Q How long have you been with the New York City Transit Authority?

A Thirty-two years.

Q Do you have experience with the Manhattan and Bronx Surface Transit Operating Authority?

A Yes, I do.

Q What is the nature of that experience?

A For a year and a half immediately preceding my present assignment I worked on the staff of the Executive Office of Labor Relations and Personnel in aligning the personnel function of the Manhattan and Bronx Surface Transit Operating Authority with that of the Transit Authority.

Q The New York City Transit Authority have a group of employees that are collectively referred to as the career and salary plan?

A Yes, we do.

Q Is this known also as -- would this encompass city-wide titles comployed by the Transit Authority?

A Yes, it would.

THE COURT: Let me be clear. You have a cateogry called career and salary?

THE WITNESS: Employees.

THE COURT: And this is identical with what is called the city-wide title?

THE WITNESS: City-wide titles.

THE COURT: Go ahead.

Q Can you describe for us please what categories of employees are covered by the career and salary plan?

A Non-operating titles, such as the clerical administrative titles, which begin with clerk and go up through the ranks to administrative associates, accounting titles that begin with assistant accountant and go up to accountants in the managerial class, engineering titles, various engineering titles, medical titles, and titles in our safety department, and also titles in our budget department, which are basically accounting titles.

Q How many employees, Mr. Jenkins, fall within the clerical, administrative and fiscal group?

A Approximately -- can I refer to some --

THE COURT: Is Mr. Jenkins familiar with this exhibit that Mr. McLaren put in?

MR. DUNN: He has seen it.

THE WITNESS: Yes.

THE COURT: I just hope we are not going to end up with a lot of contradictory figures, because Mr. McLaren was speaking in one group of categories and this witness speaks in another. I have Mr.McLaren's exhibit before me and I hope this witness will have the same, so we can reconcile things.

MR. DUNN: The only discrepancies, your Honor,

might occur as a result of Mr. Jenkins giving the figures as of a date other than the date that is reflected on this form.

THE COURT: What is the date reflected on Mr. McLaren's form?

MR. DUNN: That would have to be identified through his testimony, your Honor.

THE COURT: I wasn't under the impression that this was obsolete in any way.

MR. DUNN: No, it is not that it is obsolete, your Honor. Mr. Jenkins may pick one date or --

THE COURT: I am not worried about the exact number. In other words, this is substantially correct?

MR. DUNN: Yes, it is.

THE WITNESS: Those figures were generated by my office.

THE COURT: I am sure they were.

Just one question, if I could ask you, in this Exhibit GG2 there is the category career and salary other than professional.

Oh, I think I understand. In other words, when you describe career and salary you included --

THE WITNESS: Professionals.

THE COURT: Namely, engineering, legal --

THE WITNESS: Legal and the like, yes.

THE COURT: Fine. Thanks a lot.

Q Can you describe the titles that are included within the category of clerical, administrative and fiscal? What titles actually are employed by the Authority that fall within that classification?

A Clerical, administrative and fiscal?

Q Yes, sir.

A Beginning with the intermediate level clerk -- you want me to go through the rank of titles to the best of my knowledge or just generally?

Q I think specifically would be more helpful.

A All right. In the clerical, administrative group there are clerks that begin with the entrance level clerk or typist and going up the ladder to senior clerk, supervising clerk, administrative assistant, administrative associate, senior administrative assistant, and then clerical titles in the managerial plan which are unclassified.

In the fiscal area there are accountants, which begin with assistant accountant, accountant, senior accountant, administrative accountant.

In the parallel line in the budget area are budget examiners, assistant budget examiner, budget examiner,

administrative budget examiner, and then into the un-classified managerial series.

Q Approximately how many employees fall in that category of clerk?

A In the clerical, approximately 1200, in the clerk series of titles, and that is approximate.

Q Where are these employees engaged in their work, where are they assigned?

A For the most part, they would be assigned to either 370 Jay Street or at the World Trade Center. However, a portion of the clerk clerical titles are assigned throughout the system at the various car maintenance department shops and barns and the bus depots.

Q Does the employee have any right to select his work location or is he assigned --

A No. The career and salary people have no right to select their work location.

Q What determines where an employee entering the employ of the Authority as a clerk is assigned?

A Wherever the vacancy occurs at the time of that employee's coming into service.

Q Are these individuals subject to reassignment?

A Yes, they are, wherever the needs of the Authority may vary, they might be subject to reassignment.

Q Does it come to pass that in fact a portion of these clerks are reassigned from time to time?

A Most certainly.

Q Can you describe the accounting category?

A The accounting categories? Well, they begin, as I said before, with the assistant accountant --

THE COURT: Let's see. I tell you, names of jobs don't help me a lot. You have people who do filing?

THE WITNESS: Yes. We have clerks who would do routine clerical work, such as filing, perhaps writing of memos, routine clerical assignments.

THE COURT: What kind of routine clerical work goes on?

THE WITNESS: Well, let's take the function in my own particular department. The personnel in the Personnel Department, their time records, that is, they sign in and sign out and these records are then transferred on a daily basis to a time card, which becomes the basis of payment. A clerk or a senior clerk might be responsible for that function.

In addition, of course, we maintain the roster cards for every employee in the Authority and these cards have to be adjusted periodically whenever a

person either has his salary adjusted or he may be transferred, promoted, retire. These roster cards are maintained on a daily basis by clerical people in the lower levels.

THE COURT: Now somebody makes a mistake. Are these people under supervision?

THE WITNESS: In this level, yes, they are.

THE COURT: You are talking about the lowest clerk level.

THE WITNESS: The lowest two levels of clerk, a clerk and a senior clerk.

THE COURT: A clerk and a senior clerk?

THE WITNESS: Yes.

THE COURT: Are all under supervision?

THE WITNESS: Under the supervision of a supervising clerk or a higher level in the category.

THE COURT: Do they work generally in groups?

THE WITNESS: Generally -- in 370 Jay Street they generally work in groups. But the same timekeeping function that I mentioned in my own Personnel Department is carried on at every one of the Authority's field locations, a depot, a bus depot, for instance, or a shop or barn, and there you might have one or two clerks who are responsible for the timekeeping function in that

particular location, and there they might work as individuals, depending on the size of the location, or maybe two people.

THE COURT: How do they get supervised then?

THE WITNESS: They are generally supervised by an operating employee who might be responsible for them at that location, their day-to-day supervision.

THE COURT: What does the supervision consist of?

THE WITNESS: You are referring to Jay Street or at one of the other locations?

THE COURT: I suppose if they don't show up for work it is noted, isn't it?

THE WITNESS: Oh, yes.

THE COURT: This may seem awfully obvious, but still let me ask you what is done to supervise them.

THE WITNESS: Well, let's take one of the garage locations, for example. If a clerk -- there the clerk has to sign in, as clerical people have to all over, and he is generally supervised -- if he doesn't show up for work or if he fails to perform his work properly he is supervised usually by a foreman who is in charge of thatparticular work location.

THE COURT: If he is acting ordinarily, if

he is intoxicated or he appears to be ill or unusually drowsy, it would be noticed, wouldn't it?

THE WITNESS: It would be noticed.

THE COURT: What if he makes a mistake, what if his work is eroneous? Is there any way to detect that?

THE WITNESS: Well, in the payroll work there are some crossfooting totals that are done by the Accounting Department that would in most instances detect where there were errors.

THE COURT: You are talking about -- this is work with the time records?

THE WITNESS: With the time records, right. Then, of course, there are periodic audits of time records that are made by our auditing section. They would take the actual time cards and audit and total the figures and make sure that they match whatever was entered on the payroll for that specific period. There are periodic audits.

THE COURT: How often are these crossfootings done?

THE WITNESS: They are done on a payroll basis.

THE COURT: Once a week?

THE WITNESS: If it is a once a week payroll. If it is a bi-weekly payroll it would be done bi-weekly.

THE COURT: What other kinds of clerical work aside from the time records and employee records, what other kinds of clerical work do you have?

THE WITNESS: Out in the locations one of the functions of the clerical people -- we have to schedule -- for instance, all of our busses are scheduled for periodic maintenance and the clerical people would be responsible for maintaining these records to determine when a bus was due to come in for a 3,000 mile or a 6,000 mile inspection and then recording when the inspection is made, recording whatever information the Maintenance Department might reveal as a result of the inspection. This is then recorded by the clerk at the location.

All of this information is eventually fed into our computer system to determine -- again, as a crosscheck, to make sure that our equipment is maintained periodically properly.

But the basic data is gathered by clerical people in the locations. That is the reason why they are assigned -- some of them are assigned there rather than all being assigned at Jay Street.

THE COURT: Are there people in the category

of clerks and senior clerks that do that kind of work?

THE WITNESS: That do that kind of work.

THE COURT: Are they under supervision?

THE WITNESS: They are under supervision to the same extent that the other clerks are.

THE COURT: What other kinds of clerical work?

THE WITNESS: In addition to -- well, of course, the massive amount of clerical work deals with personnel records. There are personnel folders on every employee and all of the information that pertains to many are maintained in the work location and in 370 Jay Street, all the pertinent information that relates to the personnel records.

THE COURT: In addition to the payroll and time?

THE WITNESS: In addition to the payroll and time there is a considerable amount of other paperwork that relates to the personnel function.

THE COURT: Who would do that paperwork? Are you saying just filing or are you saying doing it?

THE WITNESS: I am saying recording the information as well as filing it. For example, a bus operator may be issued a violation by a dispatcher on

the street for failing to maintain the schedule. This report now comes into the central -- into the depot and it is then recorded on a master card for that particular employee. The initial data is then put into the employee's file. But the information is put on a card so that we can go to the card and see at a glance the fact that this man might have had these kinds of problems, you know, at times.

The clerical person would record on this card --

THE COURT: And it would have to be filed?

THE WITNESS: Right. We have an off-duty card. Every employee has an off-duty card. The off-duty card records every day of the man's work history for the year, whether it is his regular day off, if he works, if he works overtime. This information is recorded on this off-duty card again by the clerical people.

A bus operator picks an assignment for his weeks work and when he does this, if he works every day, this is an automatic thing, it is automatically posted on his card, but if he goes off sick we now have to post on the card that he is off sick. If he takes off on vacation or for a holiday or any other leave his off-duty card must be updated daily to reflect the changes in his

work assignment for the day. This again is done by clerical people. They would post entries on his records.

THE COURT: Any other kinds of clerical jobs ?

THE WITNESS: I think I have covered pretty much -- I think that the main clerical function is the roster card for each of our 42,000 employees.

THE COURT: The thing you were just mentioning?

THE WITNESS: No. The roster card is in 370 Jay Street. Every time there is a salary adjustment card has to be marked for salary adjustment. The Payroll Department has to be notified to adjust each individual's salary via a payroll notice. These things are done by lower level clerical people.

THE COURT: There again under supervision?

THE WITNESS: Under supervision.

THE COURT: What if they make a mistake?

THE WITNESS: There are certain checks and balances, but I guess that the most efficient check is the frequency of the audits that are made.

THE COURT: That would uncover mistakes in this process?

THE WITNESS: That would uncover mistakes in

time. I am sure there have been some that the mistakes have not been found for some period of time. There is an audit procedure, as it would, I guess, be in any bank, that is effective over a period of time, if an individual made a mistake.

THE COURT: When you say frequent audits, how often are these salary records audited, whatever audit you are referring to?

THE WITNESS: I would say salaries probably once or twice a year and then there are spot audits.

What we do -- what they would do, they would get a printout at the end of the year on a listing of gross earnings for all people in specific titles. We know if an individual works his regular day, he is going to come up with a certain annual salary. If that annual salary is exceeded by some arbitrary figure, ten or fifteen percent, which makes it abnormal, they would look at the location where this man works and go into it in more detail.

THE COURT: I guess if the employee was paid the wrong salary he would complain?

THE WITNESS: If he was paid too little he would complain.

THE COURT: How many clerks and senior clerks are there?

THE WITNESS: I don't know if I can give you exact numbers. It is strictly a guess because the information I have is for the clerical grouping.

THE COURT: You do your best to estimate.

THE WITNESS: The clerks and senior clerks. Five hundred.

THE COURT: Five hundred. What does an assistant accountant do?

THE WITNESS: An assistant accountant would be the individual who would be conducting the audits that I mentioned before as far as payroll is concerned. They also are involved with the preparation of the payroll itself. They are responsible for taking the information that comes off of the time cards and converting that into the dollars and cents figures that eventually appear.

THE COURT: Are they under supervision?

THE WITNESS: Yes, they are under supervision.

THE COURT: Who supervises the assistant accountants?

THE WITNESS: A supervising accountant.

THE COURT: Who supervises the supervising accountants?

THE WITNESS: We would go to administrative accountants.

THE COURT: The supervising accountants, they are under supervision?

THE WITNESS: They are under supervision.

THE COURT: When I asked you about supervision, I mean the kind of supervision where if a person came in late or was absent it would be noted. Right?

THE WITNESS: Yes.

THE COURT: If he was ill or intoxicated or acting oddly on the job he would be seen and noticed; you understand that?

THE WITNESS: Yes, I understand that.

THE COURT: If an assistant accountant makes a mistake, how would that be detected?

THE WITNESS: By the same audit procedure I described before.

THE COURT: How many assistant accountants are there, if you can estimate that?

THE WITNESS: Strickly an estimate. Of course, I can give you estimated figures if I had a budget book with me, but I will make an estimate in terms of strictly an estimate.

Not more than eighty or ninety.

THE COURT: Eighty or ninety. Okay.

THE WITNESS: If you want specifics we can provide specific numbers.

THE COURT: Sure.

What about these people that work under the

heading of engineering? What's the lowest level there?

THE WITNESS: There is a series of training titles in engineering. They vary depending on the skills.

THE COURT: Let's hear what some of them do.

THE WITNESS: Well, w e have people in the drafting area who are required to have some educational background in drafting.

THE COURT: They don't have to be a graduate engineer, right?

THE WITNESS: If I am not mistaken, I think all of our people under engineering titles are required to have a bachelor's degree.

THE COURT: Okay.

THE WITNESS: At least in our engineering titles. In the training titles it may not be required, but all of our engineers are required to have a bachelor's degree.

THE COURT: You have a group of draftsmen?

THE WITNESS: There are some technicians who are not engineers and probably are not required to have degrees.

THE COURT: What do they do?

THE WITNESS: I couldn't really say without having the specs of the job in front of me, but the numbers are relatively small in the engineering and architectural group. It is 188 in the two groups.

THE COURT: I have got on that Exhibit GG2, professional engineering, total of Rapid Transit and MABSTOA, about 1100.

THE WITNESS: Let me explain. The figures that I have been giving you are those who work for the Transit Authority and whose various salaries are not reimbursible by the City. We have a large group of engineers who work for the Transit Authority and who are on the Transit Authority payroll or capital budget who are reimbursed by the City. This is the construction engineer group. When I refer to people on the Authority payroll, I am referring to those in operations and not on the capital budget.

THE COURT: The figures you gave me as far as clerical and accountants --

THE WITNESS: Are total. With engineers we have this breakdown.

THE COURT: That isn't what I am particularly interested in.

If you could tell me -- I take it that Mr.

McLaren's exhibit is correct, you have about 1100 people all totaled.

THE WITNESS: All totaled on both capital, budget and operating. Did he specify that? Does he refer to capital budget?

THE COURT: I do'nt think he does. It is not material to me.

How many of the 1100 would ycu say worked under some kind of supervision, they work in an office where they could be observed in the way I have described to you?

THE WITNESS: I would say less than 100. I would say 120, 130. That figure is 188 on the City payroll. Those on the capital budget are construction engineers who work in the Second Avenue Subway and most of them I would say spend most of their time in the field.

THE COURT: So it is only about how many?

THE WITNESS: I would say 120 whose job functions would be in an office atmosphere.

THE COURT: You mentioned people in safety work. What do they do there?

THE WITNESS: We have a staff of safety coordinatory, all of whom come from operating supervisory titles, and they are assigned to all of the operating

depots to observe and correct safety problems that might arise.

THE COURT: This is more of an administrative job?

THE WITNESS: It is an administrative job, but these people come from an operating title. The only way you can get into that title is to come from one of the operating supervisory titles.

THE COURT: You mentioned budget examiners.

THE WITNESS: Budget examiners.

THE COURT: Is that again a kind of administrative --

THE WITNESS: It is an administrative title and deals with the creation and administration of the Authority budget.

THE COURT: Okay.

What I was trying to do was to cover -- I don't know whether it is absolutely exhausted, but we were trying to cover the categories of office help. Have we pretty much done that?

THE WITNESS: Yes, other than the legal we have covered it. That is professional. Yes, we have covered it.

THE COURT: How many lawyers do you have?

THE WITNESS: In the Legal Department we have 160. That would be lawyers, claims examiners, law clerks, but not clerical people. All people that are associated with the legal aspect of the business.

THE COURT: The lawyers work in the office, don't they?

THE WITNESS: Yes.

THE COURT: They would be observed?

THE WITNESS: They would be observed.

THE COURT: How many lawyers, claim agents?

THE WITNESS: 160.

BY MR. DUNN:

Q Is that the figure for lawyers?

A That is the figure for people in the legal-accounting group.

Q Does that include clerks?

A Not the clerical people, no. In the legal-accounting group, which would be your law clerk, your claims examiner and your lawyers, but not your clerical or administrative people.

Q You said legal-accounting?

A I said legal occupation group.

THE COURT: I think you described lawyers, claims agents, law clerks.

THE WITNESS: Right, but not clerical people, not clerks, senior clerks --

THE COURT: And you gave me a figure of about 160.

THE WITNESS: Yes.

THE COURT: And they would be working in offices and be observed?

THE WITNESS: Generally, yes.

THE COURT: Under supervision?

THE WITNESS: Yes.

THE COURT: What about secretaries? Where do they fit in on Mr. McLaren's chart?

THE WITNESS: They would fit into the clerical occupation group along with the clerk-typist, senior clerk, supervising clerk, et cetera. There are some people who hold the title of secretary.

THE COURT: Is that in addition to the 1500 you mentioned?

THE WITNESS: No. I think the figure I gave you of 500 was the first two levels of clerks, clerk and senior clerks. We have supervising clerks and we have stenographers. A stenographer may be assigned as someone's secretary. That is the third and fourth level. You start with clerk and typist, then we go to senior clerk

and then supervising clerk. We have a parallel series of stenographers where the stenographer would be equated to the senior clerk. Then the stenographer series would go up to supervising steno and either a steno or supervising steno might be assigned as a secretary.

THE COURT: Do they work under supervision?

THE WITNESS: Yes, I would say they work under supervision.

THE COURT: How many of those are there? How many in this secretarial category you just mentioned?

THE WITNESS: Again a guess. Perhaps 150 to 200.

THE COURT: Now, there is a subject which I don't understand completely, but I will just work it in here.

We have reference in this case to city-wide titles and I think you told me earlier this afternoon that the category of career and salary is identical with city-wide titles.

THE WITNESS: City-wide titles.

THE COURT: Do you have any jobs at the Transit Authority which although not strictly speaking city-wide titles are functionally the equivalent of city-wide titles?

THE WITNESS: No. Maybe I can explain it this way, if I may: A city-wide title is a title for which an examination is conducted by the City Department of Personnel and the resulting list may be used by any agency in the City. That's a city-wide title. With all of the Authroity's operating titles, the examinations are given and these titles are used solely within the Transit Authority, that is, the operating and maintenance titles are non-city-wide titles and the examinations, when given, the list resulting from those examinations is used solely within the authority.

THE COURT: I suppose it may be that -- well, no, I won't suppose anything.

Is there a class of jobs though that we have just talked about that aren't city-wide titles, they are Transit Authority classifications, are there a group which are basically the same as City jobs as far as what they do?

THE WITNESS: No.

THE COURT: You don't think so?

THE WITNESS: I am fairly -- I am pretty positive.

No. The functions of the jobs that I just described to you in the various occupation groups that are career and salary, there are no comparable jobs in the Authority. If there were the City would not permit us to have an examination and use that list exclusively for the Authority.

THE COURT: In other words, their jobs are different?

THE WITNESS: Their jobs are different. Where the Authority in the past has tried to have titles created wholly within the Authority the City Department of Personnel has looked at the job and said you can't have them wholly within the Authority because there are

other agencies whose duties and responsibilities are comparable, and therefore we would be forced to use the city-wide list.

THE COURT: Don't you have some janitorial help, cleaning people, people who do maintenance work?

THE WITNESS: Yes, in the titles of porter, railroat caretaker.

THE COURT: How about at your buildings, at Jay Street?

THE WITNESS: No. The cleaning services at Jay Street by the contract. The same applies to the World Trade Center. The offices at the World Trade Center are by contract.

THE COURT: Would that be true say out at big bus depots?

THE WITNESS: No. The railroad caretakers function is to maintain cleanliness of the bus depots and the shops and the locations away from Jay Street, because I imagine that we couldn't get the contractor to furnish that kind of services, because we are talking about --

THE COURT: Let's get that. You are speaking of the depots, the repair yards

THE WITNESS: Repair yards, the shops. The porter function there are supplied by railroad caretakers and porters.

THE COURT: Excuse me. You said it two or three times, but the job title is railroad --

THE WITNESS: Railroad caretaker.

THE COURT: And what other?

THE WITNESS: The railroad porter was the individual who maintains the cleanliness of our stations. That's the distinction between the two titles.

THE COURT: In the classifications that Mr. McLaren gave, would that be under maintenance of way, the railroad caretakers?

THE WITNESS: No. The railroad caretakers would appear under whichever department they were assigned to. For instance, if they were cleaning a bus depot they would appear in surface maintenance, if they were cleaning a car barn they would appear under the car maintenance department, if they were cleaning stations they would appear under the station department.

The caretaker functions --

THE COURT: He has under Rapid Transit car maintenance employees, 4,622.

THE WITNESS: That would include the railroad

caretaker who was assigned to clean the car maintenance barns and shops. You see, these titles are operating titles and would be properly included within the departments to which they are assigned.

THE COURT: Okay. I wanted to explore what that office help did and then we got off into the cleaning.

Mr. Dunn, why don't you go ahead.

While we are on it, the railroad caretakers, are they supervised?

THE WITNESS: Very loosely. We are talking in some instances of -- first of all, these people work around the clock, because the depot or the shop area functions generally around the clock, and in some areas there may be one caretaker on that eight hour tour, and he is not closely supervised.

THE COURT: They don't work in teams?

THE WITNESS: There are some teams -- let me say there are some teams of heavy duty cleaning damages that work in teams and gangs and are supervised. For instance, the railroad porter, a heavy duty cleaning gang would be supervised, but the railroad porter who is responsible for cleaning the station,one man may be responsible for cleaning four or five stations, he is

not supervised. He would report in by telephone from a railroad clears book and report out via telephone. But all the time that he is performing his normal cleaning functions he is not supervised.

THE COURT: Say out at a big bus depot, a repair place, don't they have a team of cleaning people like they have in this building, they have supervisors and one man in charge, a custodian? Isn't that set up in those big facilities?

THE WITNESS: No, not in the bus depot. There may be -- I would venture to say that on any one hour -- one tour, one eight hour tour, even in East New York, which is our large depot -- now remember -- let me make this distinction -- the office areas in East New York are probably cleaned by contract, that is, the office areas. We are talking about the railroad caretaker, who cleans the bus floor in the areas where the busses run through. They go through with the little mechanical vacuum cleaner. They clean the toilet facilities that are used by the maintenance people.

Even in East New York on one tour I would venture to say there are no more than three people on duty there on one tour, because they work around the clock, they are not in gangs at all.

THE COURT: Okay, Mr. Dunn.

MR. DUNN: I have nothing further,your Honor.

THE COURT: All right. Let's see what Miss DuBois has.

CROSS EXAMINATION

BY MISS DUBOIS:

Q Mr. Jenkins, with respect to the files that you said were kept on clerical and I believe career employees regarding their timeliness and performance, are those kinds of files also kep on all Transit Authority employees, including operating personnel?

A Yes.

Q And those files include records as to whether all employees are timely? Do they?

MR. DUNN: I object, your Honor, as to form.

THE COURT: Let me hear it again, please.

Q I said and do those records include indication as to whether an employee is timely.

MR. DUNN: I object, your Honor. I don't understand the word timely.

THE COURT: I think it is in context of what we already asked. Overruled.

You understand the question, whether they are prompt, their attendance?

THE WITNESS: Yes.

A Would you repeat the question, please?

Q Do the record indicate with respect to a given operating employee like a railroad porter, for example, or a ventilation and drainage maintainer, whether his attendance is regular, whether he is punctual, whether he signed out sick, whether there is a proper excuse for it, et cetera?

A The records that are maintained contains this information, yes.

Q And does it contain with respect to those operating personnel indication as to whether those people are performing properly or improperly?

A You are asking whether the records indicate --

Q Right, whether those personnel records kept on each employee contain with respect to all those employees some kind of regular reports as to performance.

A No.

Q If there is any --

A Let me make sure that I am answering your question correctly. You are asking whether or not the records contain a regular performanc evaluation, is that what you are asking?

Q No, sir. I'm sorry.

Let me go back.

I understood with respect to clerical employees that if there was any indication of improper performance, that these records kept notations of that and were kept up to date and contained that information.

A If the career and salary performance of his duty, if there were any irregularities that were noted, it would be contained in the record.

Q With respect to supervision of operating personnel, is that any system for determining on a regular basis whether, for example, an employee shows up for his job? For example, you said that the railroad porter was not directly supervised but that he called in at the beginning of his duty and he called in at the end of his duty.

With respect to all employees who aren't directly supervised, is it true that they have to call in and out in that form?

A They must report in some manner, either in person at a particular location or by phone.

THE COURT: I may have not gotten something that Miss DuBois asked. How many people in the Transit Authority have to check in as far as time? I take it that the chairman of the board doesn't punch a time clock, but most people do, don't they?

THE WITNESS: The vast majority of people, other than those in the managerial level.

THE COURT: They --

THE WITNESS: They either have to punch in a time clock or report to some member of supervision when they are reporting in.

THE COURT: Is it true that the vast majority of that reporting is done by physically punching a time clock?

THE WITNESS: Or reports to an individual. All of the operating titles, such as the motorman, the conductor, the bus operator, do not punch in time clocks. They report to a terminal, to a supervisor.

THE COURT: You are talking about the motorman, the bus drivers.

THE WITNESS: And the conductor. Train crew men and bus operators do not punch time cards.

THE COURT: How do they check in?

THE WITNESS: They check in by reporting to a terminal, to a member of supervision.

THE COURT: Why is that distinction made?

THE WITNESS: Unlike any other job in the world, transportation requires that people report every minute of the day, and a man who reports at 8:08 in the

morning may not complete his tour of duty until 6:05 at night, and he is operating a piece of equipment that may be delayed, and for this reason we don't -- they pick a run which says that the man will report at a certain time, make X number of trips, clear at a certain location at a certain time. He is paid on this basis. Therefore, he doesn't punch in the time clock.

THE COURT: So he reports personally.

THE WITNESS: Personally.

THE COURT: Who does a train crew report to?

THE WITNESS: A train crewman would report to a yard dispatcher.

THE COURT: They report personally?

THE WITNESS: Personally to a dispatcher at a terminal or a yard.

THE COURT: And so if this man was not in good condition, he was, for instance, intoxicated or looked sick or abnormal, the dispatcher would be responsible for noting that, wouldn't he?

THE WITNESS: The dispatcher is responsible for noting that.

THE COURT: Isn't he responsible for inspecting, in a way, these people, seeing that they are okay?

THE WITNESS: To a certain degree, he is responsible.

THE COURT: How long would a motorman's tour be in a given day?

THE WITNESS: Actual time from the time he comes in to the time he leaves, it would be approximately say eight hours. IT varies anywhere from seven and a half to nine and a half. But on an average it would be eight hours, eight hours and thirty minutes.

THE COURT: During that eight hours what is he doing? Is he constantly running a train?

THE WITNESS: He is constantly running a train or he may be laying off over at a terminal.

THE COURT: Is there any system for having him under any surveillance during that day, during that eight hours?

THE WITNESS: No regular system whatsoever.

THE COURT: Okay.

If there is not a regular system, there is no effort to watch him?

THE WITNESS: There is an effort to watch him, but most of the effort is concentrated where a problem develops. There are approximately 109 motormen instructors, whose function it is to cover the entire

system, and they respond to messages. In the event that there were a message in a given area or on a given line, the motorman on that line or in that given area might well be observed by the motorman instructor, but the motorman instructors primary function is to respond to messages.

In transportation, and I come from a transportation background, I started as a trolley car operator and I was a bus operator before I came into personnel, I have often said that we never supervise people in transportation, we only supervising moving vehicles.

As a bus dispatcher standing on the street I was not concerned, because of the nature of the job, as ot what the bus operator was doing. My basic function was to see that the bus got to that corner on time, picked up those people and left that corner on time, went to the terminal and came back again.

In effect, I was supervising a bus rather than an individual, and it is the nature of our business that has led to that.

THE COURT: Okay. At the end of the day does the train crew report to somebody before they leave?

THE WITNESS: I think not.

THE COURT: I take it the basic routine we have described for the train crews is also true for the bus operators, they report personally?

THE WITNESS: In the case of the bus operators they report personally to pick up their transfers. They have to check in and make sure that that run is covered.

THE COURT: There are records kept as to whether they are prompt, whether they attend, right?

THE WITNESS: Yes, because if a bus operator or a train crewman does not show at the prescribed moment when he is due to appear we have what we call board people, that is, motormen or train -- or conductors or bus operators, whose job it is to stand by to cover when people don't show into work.

The bus must leave the terminal on time, the train must leave the terminal on time. So there are people who are available.

Therefore, when a train crewman does not report on time it is noted, because a substitute must immediately be made available, and there are people whose job assignments are to cover the board, as they say.

THE COURT: And of course the people who punch the time clock, there is that record?

THE WITNESS: That's right. These are mainly in the maintenance titles that punch the clock, because their tours are standard, 8:00 to 4:00, 4:00 to 12:00, 6:00 to 2:00. They are standard eight-hour tours and the maintenance people punch the time clock.

THE COURT: I take it there is a system so that if somebody has a problem about being late, that is noted and something can be done about it, right?

THE WITNESS: You mean if the maintenance man who punches the time clock fails to show on time?

THE COURT: This is obvious, but let me just ask it. The maintenance worker punches his time clock, he is supposed to get there 8:00 a.m. every day. He is irregular. He gets there 8:25 or 8:40 and so forth.

Now, I suppose there is some system of picking that problem up?

THE WITNESS: Yes.

THE COURT: And something is done about it, right?

THE WITNESS: Definitely.

THE COURT: Okay.

BY MISS DUBOIS:

Q Could you tell me in which titles the employees neither punch a clock nor do they check in personally at a terminal?

THE COURT: He said it is mainly executives.

Q Are there any other than the executive-managerial titles?

A Not to my knowledge.

Q Does every Transit Authority employee have some -- and I am not talking about the very highest levels, I am talking about operating, et cetera employees -- do they have some person, whether or not you call it a supervisor, who is responsible for assessing their performance in the sense that if a report comes in that somebody is performing badly, is there someone for each level of employee who is responsible for taking action?

A If a report comes in?

Q Yes. Is there some formal supervisory structure that would include all employees so that any given train conductor would formally have some supervisor , some person, who is responsible for his performance?

A Yes. I would say yes.

Q You said during an eight hour tour, the bus operator does not have to report in --

A He reports in at the beginning of his tour of duty. At the end of his tour he may very well be relieved on the street by another bus operator and he does not report after that since we put in exact fare and he is no longer responsible for turning in funds. So he has nobody he reports to at the end of his duty.

If he is taking a bus into the garage, he takes the bus into the garage and does not report to anyone.

Q If the bus were to go off schedule, would there be any system of checking? In other words, is there any system of determining if, after four hours, a given bus is simply not on schedule at all, it disappeared, has had an accident or gone to the wrong borough? Is there any system by which the bus' operations is checked?

A Not on a regular basis. In the Surface system there are patrol cars whose basic responsibility is to respond to emergencies.

Q I want to show you a list, Mr. Jenkins, which the parties have stipulated are entry level titles in the TA except to the extent that the asterisks indicate the titles of both entry level and promotional.

MISS DU BOIS: For the record, your Honor, this is Stipulation No. 31 at page 50 of the black book.

THE COURT: All right.

Q Regarding the first listed conductor, could you tell me whether platform conductor is included within that title?

A Yes, it is.

Q Would you briefly describe the duties of a platform conductor?

A Crowd control. That's as brief as I can make it.

Q How long does an employee ordinarily serve as a platform conductor before he goes on to be a train conductor?

A I am afraid I can't answer that question. I don't know.

Q Let me ask this: Is it true an employee ordinarily does serve for at least some period of time as a platform conductor before he goes on to be a train conductor?

A You are getting into areas of operation that are really outside the area of the Personnel Department.

Q You don't know that?

A I don't know. I can say this, if I may: We may not have any platform conductors in a very short time because of the present -- it is one of the jobs we

are looking to eliminate because of the present budget requirements. It has been one of my areas in the last couple of days.

Q Do you know the length of the period of probation when an employee gets an entry level job?

A Six months.

Q Is there any period of probation when an employee, after serving in an entry level job, takes a promotional test and then obtains the promotional job?

A Six months.

Q Six months for the promotional job as well?

A Yes.

THE COURT: You have the six months probation on the new employee?

THE WITNESS: On the entrance level, then on promotion to a higher level and every time he is promoted he again serves in the new title six months probation.

THE COURT: Is there any special surveillance over a probationer?

THE WITNESS: There is this surveillance: The Department is responsible for reporting to the Personnel Department three times during the probationary term an evaluation of the probationers services, which covers

mainly his attendance and lateness records and any reported violations of rules.

Q And at the end of the probationary period, is it true that a decision is then made whether to give the person the full tenured -- the rights of a tenured employee in that position?

A Yes, a decision is made not earlier than two months in the probationery term and not later than I think it is three weeks before the end of the probationary term to allow for administrative paperwork.

Q And if in a given promotion level title like motorman the Transit Authority determines not to give the employee tenure, what happens to him? Is he retained?

A He is returned -- if the title is a promotional title to which he took a promotion test, he is returned to the lowest title.

Q In which he has tenure?

A In which he has tenure.

Q On the entry level, is there a period, aside from probation, is there also a period of training, whether formal or informal, ot each of the jobs?

A Other than very limited areas of highly specialized skills in which the examination would have already determined the man's capabilities to perform the

job, the answer is yes, there is a period of formal structured training for the vast majority of the titles

Q And how long does that period go on?

A It varies from title to title.

Q Does the variation depend upon the sensitivity or importance of the job?

A Correct.

Q Can you give us any idea of the range of time that it varies, just roughly?

A Anywhere from two weeks to four months.

Q On the list that I gave you a copy of, sir, it lists bus operator and conductor separately. Isn't it true that there is one test in fact for bus operator-conductor in one list?

A In the past there has been one list for both bus operator and conductor. That is open competitive: Let's make sure we are talking about open competitive.

Q How long must an employee ordinarily serve in an entry level job before he is elibigle to take a test for a promotional job?

A It varies, but I think that the minimum in one year.

Q And what would the maximum be?

A It might be three years.

Q Again, is the variation related to the sensitivity or complicatedness of the job?

A Yes.

Q I asked the formal eligibility period. What I would now ask is how long, and roughly, do the employees in fact serve on the entry level before they take a promotional test?

A In fact before?

Q In other words, I understand exams are given every few years, and I want to know if there is a significant difference between the formal eligibility one to three year range and what in fact an employee ordinarily -- the period of time he would in fact ordinarily spend on the entry level.

A That would depend on the circumstances. The life of an examination is a minimum of one and a maximum of four years, and if an individual came on the property three years after the last list was established, he would be eligible to take an examination one year later, but if he came on the property two years later, it might be four years. It would vary depending on the circumstances as to when the individual came, when the exam was given, when the next exam was being scheduled.

Q Once an employee takes a promotional level

examination, approximately how long is the period between his taking of the exam and the time when he might actually get promoted to the job?

A Depending on his place on the list, it could vary anywhere from ten months to, of course, up to the life of the list, depending where he was on the list.

Q And the life of the list could vary up to four years?

A Most lists unless exhausted, do last four years.

THE COURT: I am a little lost as to what we are getting at now.

MISS DU BOIS: What I am trying to get at is that we have had a lot of discussion in this case about different kinds of jobs, motormen, tourmen, which are promotional titles, and, on the other hand, we have things like bus maintainers, cleaners, platform conductors, which are entry level jobs.

What I am trying to establish, and I really think that I have covered most of it by now, is that there is a substantial period of time after an employee comes in before he can even become eligible for such jobs as motorman during which he has to go through training

on both levels as well as probation on both levels and that it would range up to -- well, if we add the years, I wouldn't try to sum up but --

THE COURT: A fellow comes in as a car cleaner. Now, if he does well and is qualified, he may ultimately get promoted and get to be a motorman, right?

THE WITNESS: Certainly, ultimately, yes.

THE COURT: But I take it that just because he gets hired as a car clearner it doesn't automatically force the Transit Authority to promote him?

THE WITNESS: No.

THE COURT: There are people who might be good car cleaners and not good motormen, right?

THE WITNESS: Correct.

THE COURT: And the Transit Authority has the right to choose what they are going to do, right?

THE WITNESS: We have the ability to choose as a result of the examination and the normal selection process.

THE COURT: There is a selection process over and above the examination, isn't there?

THE WITNESS: Yes, there is.

THE COURT: You look at a man and his characteristics?

THE WITNESS: Yes. There is a selection process over and above the examination, certainly.

THE COURT: I want to ask something that just came to me. In the supervision and work with the people on probation for that six month period and otherwise, is the Transit Authority alert to people who have narcotics problems? I ask that in a very general way and see what you can comment on that.

The reason I ask is this: -- well, you try to answer it.

THE WITNESS: I will try to answer it this way: I think that a problem employee, whether it is a narcotic problem or a drinking problem or whatever it may be, only comes to the attention of the Authority in general when it affects his job performance, his attendance, his promptness in reporting to work, the fact that he may be involved in passenger complaints or accidents.

It is the job performance that really indicates to the supervisor that the man may be having a problem, because when the bus operator, after having reported in the morning, goes out on the road, as I pointed out, he has very little supervision during the day. If we get passenger complaints, if he is involved in accidents if he fails to report to work on time, if he is excessively

absent, then we recognize that there is possibly a problem.

Does that answer your question?

THE COURT: Yes. That's a start. I don't want to get into something that's covered, but I would like to know something about this problem about whether people who have drug problems can be detected before they cause some calamity our there, you know, before it can be known, because that's a problem. We are talking about hiring methadone people.

The possibility has been, it seems to me, continually suggested that someone can be a methadone patient and then they can suddenly revert to heroin or excessive drinking and be a problem, because an accident not be detected and, of course, then you would have a tragedy.

I take it regardless of methadone patients there are drug addicts in this City and you have to be alert to them now in the Transit Authority, don't you?

THE WITNESS: Yes.

THE COURT: Have you found in the years while narcotics has been a problem that you have to -- have you found people with drug problems you have discharged?

THE WITNESS: That is correct.

THE COURT: Has this occurred in large numbers? Can you give me an idea how series this problem has been to you?

THE WITNESS: I can only give you a general statement.

THE COURT: That's fine.

THE WITNESS: As far as employees, we have periodic medical examinations for some of our critical operating titles. For instance, the bus operator, the motorman, the train crewman, I believe the tour man --

THE COURT: Critical. Is this in the record now? If it is, I don't want to repeat.

MISS DU BOIS: Some of it is. There is a stipulation which appears at page 40, number 26(b) relating to the periodic physicals for bus operators, conductors, motormen, tourmen and surface line dispatchers. There is also testimony that Mr. McLaren gave which is discussed in here somewhere, and I just don't have the cite right now, where Mr. McLaren states that the title for which this kind of periodic analyses are given are selected in accordance with the sensitivity and importance of the job and that at the present time something like a third of the employees get, I think, periodic physicals.

THE COURT: Maybe we could --

MISS DU BOIS: It is also stipulated, your Honor, in (a) on page 40, number 26(b), all prospective employees, and I think this relates both to entry level and promotional, who are under age 35 are given drug detection urinalysis as part of their physical examination.

THE COURT: Apparently a good deal of this is stipulated, so we won't trouble you with that.

Basically what this stipulation relates to is a system of regular testing for various classes of employees, right, Miss DuBois?

MISS DU BOIS: Yes, sir.

THE COURT: That we have.

Aside from that, do you sometimes find evidence of people being on narcotics because of their behavior?

THE WITNESS: That is correct. Because of the pattern of their behavior, individuals may be referred to the medical department for examination by the operating department, based, as I said before, on some things that occur during their job performance.

THE COURT: Is there any way you can give me an idea of the frequency or volume of that problem?

THE WITNESS: No, I cannot.

THE COURT: Are these instances of finding odd behavior and finding narcotics, has that happened once a year? Is it a very rare thing or not so rare?

THE WITNESS: It is a part of our medical department's records and I don't have knowledge specifically as to the volume.

THE COURT: Do you know of any instance where an accident has been caused by a person under the influence of narcotics?

THE WITNESS: No, I have no knowledge of an accident in which a person under the influence of narcotics was involved. It wouldn't be under my sphere to investigate the accident. That would be between the operating department and the accident and in the case you cite the medical department.

THE COURT: Is there material on that?

THE WITNESS: There should be material on that because it is available in the medical department.

MISS DU BOIS: There is material on that. With respect to all accidents, not just personal injury but bumping of the train, routine accident reports are done which includes analyses as to whether the person had any involvement in drugs, and in deposition testimony

we were told that none of those accident reports indicated any drug involvement.

MR. SUMMERS: That is not correct.

MISS DU BOIS: After the deposition testimony before the trial or in the middle of the trial, at some point two accident reports came in and have now been submitted in evidence which apparently constitute the only two accident reports involving any indication of drug use. Those are in.

THE COURT: Can we get statistics on the number of people, aside from those accidents, the number of people found and disciplined because of a narcotics problem?

What I am getting at is this. Just going back to what I said a minute ago, it has been suggested that the narcotics people can function at the Transit Authority in a dangerous way to themselves and the public, function undetected and cause a tragedy. Obviously that is something you ought to be concerned about.

But I would like to know if there is any instances of that happening, and I would like to know how many instances it happens the other way, that is, somebody is found to be acting oddly because he is under supervision or he doesn't -- they pick up lateness or something like that, he is found to be acting oddly, then he is referred for testing or whatever, he is found to have the heroin problem, whatever it is, and he is disciplined accordingly before and in the absence of him killing himself or the public.

You get my point?

MR. DUNN: I understand what it is your Honor wants. I will attempt to obtain it. I am not sure that we will have it by Monday, which is the next meeting,

but I understand that Friday, a week from today, we will be meeting again.

THE COURT: All right, fine.

What else do you have to cover?

MISS DU BOIS: Just a few things, your Honor.

THE COURT: I would like to go over some points that I have listed.

MISS DU BOIS: I have a little more on this entry promotional.

THE COURT: All right. We are close to the end of the day and I think we have to see where we go.

First of all, I wanted to get a description of some of the jobs that were applied for or occupied by the plaintiffs. For instance, Diaz applied for maintainers helper D. I wanted to get a description of that.

Secondly, I would be interested in carrying on the same kind of discussion that we had on the clerical employees, what they do and the extent of their supervision.

I would like to carry that on on other areas, like maintenance, car maintenance, maintenance of way. I don't want to just stop with the clerical employees.

Thirdly, we had a reference by Mr. McLaren in his recent testimony to a distinction between what he called critical and non-critical positions. I think that

was the terminology he used. Then we have some material in the stipulated facts along that same line.

In dealing with the alcoholic problem, there apparently is a differential in treatment between people holding certain kinds of jobs and people holding others.

Now, I am not clear what has been stipulated. We have this proposed finding of fact contained at the bottom of page 61 and the top of page 62. A great deal of this apparently is agreed, but apparently the Transit Authority won't agree to the characterization safety sensitive and non-safety sensitive or something. I can't make it out. That ought to be resolved.

But I definitely want to know if the Transit Authority has classifications of safety sensitive or critical employees or positions and non-safety sensitive and non-critical. That ought to be laid out in this case and a-l the evidence that relates to that. I was going to try to get into that.

MISS DU BOIS: I had planned to cover some of that if you were interested in it and I could go through the questions I have and see whether that covers what you are interested in.

THE COURT: All right.

MISS DU BOIS: I hadn't planned to do it

extensively because I think there are a great number of stipulations that cover enough of it.

THE COURT: Are there stipulations?

MISS DU BOIS: There is a great deal in the stipulations and in the testimony regarding the alcoholic policy and also the diabetic and epilepsy in which Mr. McLaren and Mr. Warren make very clear -- well, it is clear that with respect to the alcoholic policy they make very clear which positions are considered sensitive and non-sensitive.

THE COURT: Is this spelled out in the recod now?

MISS DU BOIS: It is, you Honor.

THE COURT: Look at your black book on page 63. You say, "The main areas of disagreement appear to be plaintiffs claim that approximately 60 percent of the TA jobs are considered non-safety related for purposes of enforcing Rule 11A."

I don't claim to be slightly conversant with that phase of the case, but I just don't want the record to close and then we are trying to deal with the record and it is all vague.

MISS DU BOIS: What I am saying is that there is significant dispute as to the stipulations. I

agree on something like that. For example, I considered that claim an obviously significant fact. What I am saying is that to date we feel that on most of those significan issues the depositions of Mr. McLaren and Mr. Warren are dispositive, that they go through kinds of jobs.

Mr. Warren talks about specific jobs and there is no contrary evidence of that. That's what we hadn't introduced.

THE COURT: I think it would probably help us all to check that. I just feel that it is probably an important subject and I don't want to have the record closed in any state of confusion.

There has been a lot of proof on a lot of subjects and I think over this weekend we will look over that and you might look over that.

What I would appreicate having is simply the followup to what I heard of Mr. McLaren's testimony that he has in his mind critical versus non-critical jobs.

Now,we didn't take his time to try to get a comprehensive listing, but if there is a comprehensive listing that the Transit Authority has under its consideration that should certainly be on the record. If it already is, and if it is clear, fine. I don't mean every

last cateogry, but I mean get the basic divisions.

MISS DU BOIS: Our sense was, your Honor, that there was not a job by job listing but that there was fairly clear testimony by Mr. Warren, who is head of the alcoholic program, as to the kinds of positions which were considered so sensitive that alcoholic or an active drinker would be demoted and other kinds of positions that were not so sensitive.

THE COURT: So you feel it signifies where the lines are drawn.

MISS DU BOIS: In each and every job we could give your Honor a sense, 60 percent, 40 percent, and categorize the types of jobs, like railroad clerk, motorman, porter, where Mr. Warren felt it was important enough to have urinalysis done, et cetera.

THE COURT: All right. Why don't you go ahead.

MISS DU BOIS: All right.

BY MISS DU BOIS:

Q Mr. Jenkins, on the promotional level, I would like to ask the same question about the training that I asked for the entry level.

Is there a period of training for each pro - motional level job?

A Yes, there is a period of training for each promotional level job, most. I wouldn't want to state for every.

Q For the majority?

A Yes.

Q Does the length of the period of training vary as it did with respect to entry level jobs, depending on sensitive or complicated nature of the promotional job?

A I would say no.

Q No? Is there a set period of length of time for training on the promotional level?

A If a man is being promoted out of an hourly operating title to a supervisory title there is a set period of training, which is approximately three weeks.

Q If he is supervising the same kind of job he was in. What about with respect to other promotional titles?

A The career ladder for all -- for most operating titles is straight up one step at a time. So he would be supervising people that are working in the title from which he came.

Q Do you know the kind of training a motorman receives?

A Yes, I have some idea.

Q Could you describe it?

A The motorman receives a training period that -- training that varies depending on the division to which he is assigned. He receives approximately two weeks of classroom training and then approximately two weeks of equipment training in the yards, followed by a training period of approximately a month on route familiarization, in which he operates a train in passenger service under the control and supervision of another motorman. He then returns to the school program, where he has a period of final training of about a week or two weeks. This time varies depending on the zone to which he is assigned because of the differences in the number and the lengths of the routes to which he may be assigned to operate or the complexity of the yards that service those areas.

THE COURT: We have a stipulation as to certain titles. Stipulation 31 is entry level, right?

MISS DU BOIS: Yes.

THE COURT: That means you don't have a prior TA position to qualify?

THE WITNESS: Entry level, no.

THE COURT: I take it that other things are

called promotional level positions?

THE WITNESS: That is correct.

THE COURT: That would include motorman, bus driver.

THE WITNESS: Bus driver, conductor, are the two entrance level titles for all of our operating titles.

THE COURT: How about motorman?

THE WITNESS: The motorman is a promotion from conductor.

THE COURT: So you cannot, without prior Transit --

THE WITNESS: You must go from conductor to motorman.

THE COURT: Okay, fine.

BY MISS DU BOIS:

Q Could you describe the training for motorman -- I am sorry -- for towerman in the same way you just went through for motorman?

A No, I am sorry. I cannot.

THE COURT: Maybe I have a wrong idea what is significant, but it seems to me we should get away from the motorman, the towerman, which we really have seen so vividly and have been described constantly in this

case, and get fleshed out some of these other positions, the maintenance workers, what they do, how they are supervised, and the cleaners. There are six categories of car maintainers. I don't assume that all those people are endangering life and limb, but I really don't know much about them.

MISS DU BOIS: I would like to just established a couple of more things about promotion and then I will go on to those titles.

Q Is there in addition to the Civil Service test for promotion a medical or physical examination for promotion?

A Yes. Every candidate who has passed the competitive examination for promotion is given a medical. In some cases there may have been qualifying examinations.

Q Do you know how the classifications between entry level and promotional level jobs is made or was in the past made? Has it any relationship to the sensitivity of the job?

A I have no idea.

MISS DU BOIS: I can run through a couple of the positions. I didn't think it was that important.

Q Can you describe the job of railroad porter?

THE COURT: We are in our perenial situation.

I am late for a 4:30 hearing, and yet I think this is more important to cover.

MISS DU BOIS: I could run through a few of the positions. I don't know if Mr. Jenkins is as familiar as the people who have testified on depositions -- about the differences between operating and non-operating positions for purposes of the alcoholic program. Maybe he is.

THE COURT: Look, Miss DuBois, I would like to get an idea -- you know what the issues are in this case -- of what people do and how they are supervised. The formal titles, formal classifications, don't make nearly as much difference to me as finding out the kind of thing that I was asking this gentleman about the clerical. But it doesn't stop with the clerical.

We are limited on time and I just think that he has to come back. I don't see any way I can continue very much longer this afternoon.

MR. BALBER: We have witnesses scheduled solidly from 10:00 a.m. on Monday.

THE COURT: I thought we were meeting at 9:00, in any event.

MR. BALBER: We scheduled witnesses starting at 10:00.

THE COURT: Can you come back at 9:00 o'clock Monday?

THE WITNESS: Yes, sir.

MR. BALBER: If Mr. Jenkins isn't qualified in the operating titles might I request that another witness be made available.

THE COURT: It seems to me you are very familiar with everything we have asked you so far. The kind of questions I asked you about the clerical, if I asked you about the maintenance of way, the car maintenance, the cleaning jobs, what they do and how they are supervised, can you cover that?

THE WITNESS: I can cover it, but in a somewhat limited way.

MR. SUMMERS: Your Honor, may I interrupt for a moment?

THE COURT: Yes.

MR. SUMMERS: At a previous session we told the Court that if the Court wants specific knowledge about a particular job we will bring in the operating people who do those jobs, supervise them. This is the information we would like to get to you if you want it.

Mr. Jenkins is probably generally familiar with this area. We would like to give you the people who

do the job, not Mr. Jenkins. He doesn't do it.

THE COURT: Okay.

MR. SUMMERS: I want to be told what areas you are interested in or Miss DuBois is interested in .

THE COURT: That's fair enough. I think I have said it. I do not need to hear about motormen. No offense to anybody who is asking about motormen. I am sure there is much to be covered. But I really feel I do know something about that. It is these categories, the maintenance people, the maintenance of way people, the equipment maintenance, car cleaning, bus cleaning. Those categories loom very large in this list we have on page 50 of the stipulated facts and they seem to me to be positions that I would like to haveinformation

.

MR. SUMMERS: We had a half dozen people in court one day ready to proceed in that manner and we got detoured somehow.

THE COURT: Please, just take it easy. I really apologize. I make a blanket apology for everybody's inconvenience. But I really can't help it at this point. If it is awkward to bring people in --

MR. SUMMERS: I am not suggesting it is too much trouble to bring them back. I am suggesting we were

thinking that way and were ready to go but we got detoured.

MR. BALBER: Your Honor, do you think we will be able to cover this sufficiently between 9:00 and 10:00? We also have a series of witnesses scheduled after 10:00.

THE COURT: I doubt it.

MR. BALBER: Your Honor, it is about six witnesses who have arranged their personal calendars to be here.

MR. DUNN: We have an additional problem, your Honor. The weekend tomorrow and Sunday.

THE COURT: It is no problem for me. We can start at 10:00 and use all the time you have. I thought we were going to start at 9:00.

MR. DUNN: The Law Journal says 9:00. I asked your law clerk. She said 10:00. She confirmed it was 10:00 o'clock.

THE COURT: I don't think there is any particular impass. You have a group of witnesses on for Monday and if there are other witnesses I think I made available some time the following Friday and you will just have to work around it.

MISS DU BOIS: Fine. Maybe we can finish this by the afternoon.

THE COURT: Let's start at 10:00.

You work it out. I think the Transit Authority knows what we are interested in.

Do you have any more questions of Mr. Jenkins?

MISS DU BOIS: No, sir. I have one specific one. May I examine the notes and the book that he was looking at to see whether it is something that we should know, if it categorizes jobs in some way? I would like to have a chance to look at it.

THE WITNESS: It is a public fact book. It is public information.

THE COURT: Do you have any more questions for him?

MISS DU BOIS: No, sir.

THE COURT: Do you want him back Monday?

MISS DU BOIS: No. What I would like is for us to be able to proceed at 10:00 with our witnesses and to fit in whoever the TA wants to call.

MR. DUNN: Dr. Lynch at 3:00 o'clock.

MISS DU BOIS: I don't know. We want to call --

THE COURT: Let's just finish the record. We have a witness on the stand.

As far as I am concerned, subject to the

Transit Authority bringing in these other people who are more knowledgeable on these other positions, this witness is completed.

MISS DU BOIS: Fine. That is fine with us.

THE COURT: Then we will start on Monday at 10:00. You work out the schedule for that day. If you have any further witnesses to hear we will work out times to hear those.

MR. DUNN: We are only bringing one witness for Monday, your Honor.

THE COURT: All right.

(Adjourned to February 3, 1975 at 10:00 o'clock a.m.)

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HAROLD L. WIGG, JR., M.D.

DATE OF BIRTH: June 23, 1924
United States of America

CURRICULUM VITAE TO JUNE, 1973

ACADEMIC TRAINING

1944 B.S., Hampton Institute, Hampton, Virginia
1946 M.D., Meharry Medical College, Nashville, Tennessee
1958 Certificate in Psychoanalysis, William Alanson White Institute, New York City

HOSPITAL TRAINING AND RESIDENCE

July 1946 - June 1947: Rotating Internship, Harlem Hospital, New York City.
July 1947 - December 1947: Admitting Physician and Surgeon, Harlem Hospital, New York City
January 1, 1948 - December 31, 1949: Assistant Resident and Resident Psychiatrist, Bellevue Hospital, New York City
January 1, 1950 - December 31, 1950: Resident Psychiatrist, Bellevue Hospital, New York City
January 1, 1951 - August 16, 1951: Assistant Alienist, Bellevue Hospital, New York City
August 17, 1951 - January 15, 1955: Senior Psychiatrist, Bellevue Hospital, New York City

HOSPITAL STAFF APPOINTMENTS

1. September 1953 - June 1954: Assistant in Psychiatry, University Hospital, New York City
2. January 1954 - February 1955: Associate Attending Psychiatrist, Manhattan General Hospital, New York City
3. January 1961 - December 1964: Assistant Psychiatrist, New York Medical College, Metropolitan Hospital Medical Center, New York City
4. January 1961 - March 1971: Associate Attending Psychiatrist and Director, Drug Addiction Service, Morris J. Bernstein Institute, Beth Israel Medical Center, New York City
5. June 1965 - March 1971: Director, Methadone Maintenance Treatment Program, Morris J. Bernstein Institute, Beth Israel Medical Center, New York City
6. September 1965 - August 1968: Coordinator of Psychiatric Services, Morris J. Bernstein Institute, Beth Israel Medical Center, New York City
7. March 1971 to date: Associate Director of Psychiatry for Addictions, and Chief, Methadone Maintenance Services, Morris J. Bernstein Institute, Beth Israel Medical Center, New York City
8. May 1971 to date: Attending Psychiatrist, Beth Israel Medical Center, New York City
9. January 1972 to date: Associate Director, Morris J. Bernstein Institute, Beth Israel Medical Center, New York City
10. May 1972 to date: Chief, Drug Addiction Service, Morris J. Bernstein Institute, Beth Israel Medical Center, New York City (See Item 4 - re-assumed Directorship of this Service).

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FACULTY APPOINTMENTS

September 1950 - August 1951: Lecturer in Psychiatry (Nursing), College of Medicine, New York University - Bellevue Medical Center, New York City.
September 1953 - June 1958: Clinical Assistant in Psychiatry, Faculty of Medicine, New York University College of Medicine, New York City.
1955 and 1956: Guest Lecturer in Psychiatry, Member of the Didactic Corps and Directorate, Institute of Psychological Medicine, Rio de Janeiro, Brazil. (Winter sessions only).
September 1958 - July 1961: Professor of Psychiatry, Yeshiva University, Graduate School of Education, New York City.
January 1961 - December 1964: Associate in Psychiatry, New York Medical College, New York City.
September 1964 to date: Faculty Member, William Alanson White Institute of Psychiatry, Psychology, and Psychoanalysis, New York City. Title of Course: Principles and Dynamics of Narcotic and other Drug Abuse.
June 1968 to date: Associate Professor of Clinical Psychiatry, Mt. Sinai School of Medicine, New York City.
September 1968 to January 1969: Lecturer in Psychiatry, Adelphi University School of Social Work, Garden City, L.I., New York

CLINIC AND CONSULTING APPOINTMENTS

September 1955 - June 1961: Panel Psychiatrist, Jewish Child Care Association of New York, New York City.
January 1957: Consultant in Psychiatry, Department of Health, Division of Mental Health Services, Government of the Virgin Islands of the United States.
February 1958 - September 1960: Consulting Psychiatrist, New York City Board of Education, Division of Elementary Schools, Special Reading Services Project.
September 1958 - September 1961: Supervising Psychiatrist, Psychological Center, Yeshiva University, New York City.
September 1961 - July 1962: Consulting Psychiatrist, Psychological Center, Yeshiva University, New York City.
September 1960 - October 1967: Assistant Director, Clinical Services, William Alanson White Institute of Psychiatry, Psychology, and Psychoanalysis, New York City.
March 1966 - June 1967: Guest Investigator and Consultant, The Rockefeller University, New York City.
June 1969 to date: Panel Consultant (Psychiatrist), Board of Education of the City of New York, Medical Division, New York City.
September 1971 to date: Consultant Psychiatrist, Louise Wise Services, New York City

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CLINIC AND CONSULTING APPOINTMENTS (continued)

October 1971 to date: Consultant to the President's Special Action Office Office for Drug Abuse Prevention, 726 Jackson Place, N.W., Wash., D.C.

December 1971 to date: Consultant to the Psychiatry Service and the Drug Dependence Treatment Unit, New York Veteran's Administration Hospital, 24th Street & First Avenue: The New York Regional Veteran's Administration Office, 252 Seventh Avenue, New York City

PROFESSIONAL LICENSES

1. License to Practice Medicine and Surgery, New York State License Number 48211, dated September 30, 1948
2. Certificate as Certified Examiner, New York State Department of Mental Hygiene, dated July 6, 1949
3. Certificate as Qualified Psychiatrist, New York State Department of Mental Hygiene, dated March 3, 1954
4. Certificate, Diplomate of the American Board of Psychiatry and Neurology, Inc. (in Psychiatry), dated December 14, 1954

MEMBERSHIP ON BOARDS AND COMMITTEES

1. Committee on Adolescent Problems, New York Society for Clinical Psychiat
2. Member, Electoral Commission, The Academy of Psychoanalysis, 1964
3. Chairman, Electoral Commission, The Academy of Psychoanalysis, 1965
4. Member, Foreign Affairs Committee, William Alanson White Psychoanalytic Society, September, 1964
5. Chairman, Arrangements Committee, The Academy of Psychoanalysis, 1965
6. Member, Ad Hoc Commission on Narcotic Addiction, New York Society for Clinical Psychiatry, New York County District Branch, American Psychiatric Association
7. Member, Methadone Maintenance Evaluation Committee of the State of Pennsylvania, Department of Health, Commonwealth of Pennsylvania, May 1971
8. Member, Ad Hoc Committee on Methadone, New York State Department of Health, July 1971
9. Member, Editorial and Advisory Boards, ADIT: Approaches to Drug Abuse and Youth, 1972
10. Member, Advisory Council, Board of Education of the City of New York, Manpower Development Training Program, Riker's Island Adolescent Center, April, 1972 - September, 1973
11. Member, Medical Advisory Committee, Heroin Research and Treatment Program, Co-sponsored by Vera Institute of Justice and Howard Samuel Pres. & Chairman, N.Y.C. Off-Track Betting Commission, May 1972
12. Program Chairman, Methadone Maintenance Treatment Sessions, International Congress on Alcoholism and Drug Abuse, Amsterdam, Holland, September 4 - 9, 1972
13. Member, Subcommittee on Drugs and Drug Abuse of the Committee on Public Health of the New York Academy of Medicine, February 1973

MILITARY SERVICE:

1. U.S. Army 7/1/43 - Honorable Discharge 7/8/46
2. U.S. Army 8/23/51 - Honorable Discharge 7/29/53

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MEMBERSHIP IN PROFESSIONAL SOCIETIES

1. 1950 to date: New York Society for Clinical Psychiatry
2. 1954 to date: Medical Societies of County and State of New York
3. 1954 to date: Fellow, American Psychiatric Association
4. 1955 to 1970: Fellow, Association for the Advancement of Psychotherapy
5. 1957 to date: College of Psychoanalysts, Rio de Janeiro, Brazil
6. 1958 to date: The William Alanson White Psychoanalytic Society
7. 1958 to date: Fellow, The American Academy of Psychoanalysis
8. 1960 to 1970: National Medical Association
9. 1964 to date: The National Council on Alcoholism, Inc.
10. 1965 to 1972: The American Medical Association

PUBLICATIONS

Trigg, H.L. and Young, E.G. Do You Know About Teen-Age Drug Dependency? Edited and distributed by Comeback, Inc., New York, March, 1966.

Trigg, H.L. Discussant: "A Twelve Year Follow-Up of New York Narcotic Addicts: IV. Some Characteristics and Determinants of Abstinence" by George E. Vaillant. Amer. J. Psychiat.: Vol. 123, 1966. pp. 584-585.

_____ Drug Addiction. In Drug Abuse (Supplementary Information for Teachers on the Use, Misuse, and Abuse of Drugs). University of the State of New York, State Education Department, Curriculum Development Center. Albany, 1967. pp. 79-83

Dole, V.P., Foldes, F.F., Trigg, H.L., Robinson, J.W., Blatman, S. Methadone Poisoning Diagnosis and Treatment. New York State J.Med., 71:5:541-543, March 1, 1971.

Trigg, H.L., The Bernstein Experiment. In Proceedings Third National Conference on Methadone Treatment. NIMH. U.S. Government Printing Office, Wash., D.C., 1970. Stock #1724-0158, pp 65-66.

Shuman, A., Feinstein, M.A., Trigg, H.L. Withdrawal and Detoxification In New York Heroin Users. (In Press) Kemp, W., Editor, Charles C. Thomas, 1972. Presented at the 15th Annual Meeting, Eastern Psychiatric Research Association: Drug Abuse, Current Concepts and Research, November 7, 1970.

Trigg, H.L. Report From the Source of Methadon Treatment. In Methadon 1971 Workshop Proceedings. Blachly, P.H., Editor. Continuing Education Publications, Corvallis, Oregon, 1971. pp. 3-5.

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PUBLICATIONS (continued)

Trigg, H.L. Clinical Problems of Selection, Prediction and Patient Failure. In Proceedings Fourth National Conference on Methadone Treatment. National Association for the Prevention of Addiction to Narcotics, New York, 1972. pp.133-134.

Richman, A. and Trigg, H.L. Assessment of Attitudes of Methadone Maintenance Patients With the Semantic Differential Technique. In Proceedings Fourth National Conference on Methadone Treatment. National Association for the Prevention of Addiction to Narcotics, New York, 1972. pp.479-481.

Trigg, H.L. Treatment of Needle Tracks in Drug Addicts, [illegible] JAMA, 221:7:720, August, 1972.

Richman, A. and Trigg, H.L., Selection of Heroin Addicts for Therapeutic Communities. Abstract in Proceedings, 100th Annual Meeting of the American Public Health Assoc., Atlantic City, November, 1972.

Richman, A., Trigg, H.L. and Slater, S. Underutilization of Methadone Maintenance Programs by Addicted Vietnam Veterans. Presented at the Second International Symposium - Drug Addiction, New Orleans, Louisiana, March 1973.

Trigg, H.L. Withdrawals and Methadone Treatment. In Drugs and Youth: The Challenge of Today. Harms, E., Editor. New York, Pergamon Press, 1973. pp.183-189

slp 849

CARL A. BEAZER, et al,
Plaintiffs,
vs. 72 Civ. 5307
NEW YORK CITY TRANSIT AUTHORITY,
Defendant.

New York, February 3, 1975.

Trial resumed.

- -

* * *

Q During your previous testimony in this case you were questioned regarding some Beth Israel maintenance treatment program nursing notes pertaining to plaintiff Francisco Diaz.

Can you describe in general how such notes are compiled?

A The nursing notes, of course, are written on only by nurses, not by any other discipline. The nurse is supposed to make an entry each time she sees a patient. That doesn't always happen, but that is the policy.

Q Do nurses make notations, are they instructed to

make notations when they have reason to suspect that a patient is abusing drugs or alcohol?

A Yes, they do receive those instructions.

Q Do the nurses' observations regarding alcohol or drug abuse that she records have to be confirmed by laboratory tests before she is allowed to enter them in the nursing notes?

A No.

Q So they can be based on simply her anecdotal observations?

A Yes, sir.

Q Do the nurses' observations have to reflect any kind of consensus by the clinic staff before she is allowed to enter them?

A Not at all. That is strictly the nurse's decision as to what she is going to put in there.

Q In your experience in the Beth Israel program, Doctor, have you become aware of entries by nurses in patients' records regarding suspected alcohol or drug abuse when in fact there was none?

A Yes.

Q Dr. Trigg, did you ever have the occasion to work closely with the particular nurse who compiled the nursing notes pertaining to plaintiff Diaz, about which you were

questioned earlier?

A Yes.

Q During your period of association with her, did you form an opinion as to her sensitivity to alcohol abuse by patients?

A I would say that I--and I don't want to downgrade anybody's character--she was a competent nurse, somewhat overzealous, described by usually reliable people as being rather rigid; worked in several different locations in Beth Israel Medical Center, prior to her terminating her employment several months ago.

The shifts in job locations were occasioned primarily by an effort on the part of the Medical Center to help her find an atmosphere in which she could adjust. Again--

MR. DUNN: Your Honor, I object most strenuously to the characterization of an anonymous witness.

THE COURT: Overruled.

Q Would you finish your answer, Doctor?

A I think I have essentially finished. I don't want to just pick on one nurse. I can say it would be correct for you to assume that I am pretty fussy about the way I run the clinics at Beth Israel, and sometimes I come down rather heavily on the staff members, and in certain areas,

diversion of methadone, improper charting, not noticing when somebody is high, and I suppose the manner in which I am fussy may from time to time intimidate certain people and get them to overchart or become hypersensitive; and I don't always agree with their impressions.

If they can live with me long enough they will get used to me. But in the beginning it can be difficult.

Q Dr. Trigg, can you describe in layman's terms what a liver profile test is?

A Liver profile is essentially--well, first of all, it involves drawing 10 ccs of whole blood, which is sent to the lab and 12 different tests are performed on it to assess the functional capacity of the liver, from the various aspects.

Q How complete a picture does it give you of liver function?

A Gives you a very complete picture of liver function.

Q Doctor, if a person is engaged in a persistent pattern of drinking such as that that was reflected in the nurses' notes you were asked to read pertaining to plaintiff Diaz, would it be reflected in a liver profile test?

A It should be.

Q Dr. Trigg, in response to a request from me did

you order that a liver profile test be performed on Mr. Diaz this past Thursday?

A Yes, sir.

Q What were the results of that test?

A The results were entirely within normal limits for this patient population.

I qualify that only because most of the patients with whom we deal have had hepatitis, which may cause some abnormalities, but this is well within normal limits.

Q Did the test give you any indication that Mr. Diaz is engaged in a persistent pattern of heavy drinking?

A The liver profile done on January 30, 1975 is not consistent with the liver profile of an individual who has a pattern of heavy drinking.

MR. BALBER: Thank you, Dr. Trigg. That concludes our direct.

THE COURT: Any cross?

CROSS EXAMINATION

BY MR. DUNN:

Q Can you tell me the name of the nurse to which you referred to earlier as having written the nursing charts?

A I was referring to a Miss Pauline Carson.

Q C-a-r-s-o-n?

A Yes.

Q Is she presently a nurse registered in the State of New York?

A That I don't know. As I testified, she left us several months ago. I have no idea where she is.

Q When you became aware of what you considered to be her deficiency did you take any notes to notify the appropriate licensing authorities in the State of New York?

A No, I wouldn't. I didn't mean to imply in that extreme of overzealousness; it is not something in this context that I would report to any licensing authority. I also testified previously that I was not aware of some of her notes until you showed them to me, Mr. Dunn. I had picked up one of her notes, which is substantiated by the laboratory data. But this was certainly, the remarks I made about Miss Carson was certainly not of the magnitude that I would report them to anybody.

Q Did you recommend her to a subsequent employer, Doctor?

A I don't recall that I did. I wasn't even aware of when she left.

Q Do you know if she is presently employed by a methadone maintenance treatment program?

A I have no idea, Mr. Dunn.

THE COURT: Did you say you did recommend her?

THE WITNESS: No, I said that I didn't even know when she left. After she left I found out that she had gone. I think it was somewhere during the summer--I'm sorry, last spring.

Q You refer to a liver profile test, Doctor. Is this also referred to as a liver function test? Are the two the same?

A I think they are the same. Technically it is a liver profile test.

Q Do you have the result of the liver profile test of Mr. Diaz with you?

A Yes, I do, Mr. Dunn.

Q May I have it, Doctor?

(Pause.)

THE WITNESS: Your Honor, I have the original and some Xeroxes. Do you want--

THE COURT: Whatever you have.

THE WITNESS: The original I need to put back in the chart, but this is a bunch of Xeroxes.

MR. DUNN: I will take the original for now and return it.

THE COURT: Would you mark it for identification? Are you going to use it?

MR. DUNN: I'm not certain. I haven't it before,

your Honor.

MR. BALBER: Your Honor, since Dr. Trigg has Xerox copies, may I have a copy?

THE COURT: All right.

(Pause.)

Q What would cause, ordinarily, Doctor, a liver profile or liver function test be ordered?

A Mr. Dunn, could I just have a clarification? Do you mean on a methadone program?

Q Any patient.

A These tests contain such important information that many doctors order them routinely as a part of their physical examination just as they order tests for venereal disease and a test plate. Those are routine parts of the physical examination.

I might add also that all methadone patients before they receive their first dose of methadone at the Beth Israel Medical Center have as part of their physical examination a liver profile in addition to other laboratory tests.

Q I assume that Mr. Diaz had a liver profile test at the time of his admission to the methadone program?

A In 1968, yes.

Q Do you have a copy of that with you, Doctor?

A I don't have that. I don't have it with me, Mr. Dunn. I did look at it.

Q For what purpose did you look at the original liver profile tests?

A Only because it was in the material which was

forwarded to me when they asked for the patient's chart from the medical center authorities. I simply read through every sheet that was sent to me. For no other reason did I look at it.

Q Would a change of a liver profile be significant?

A Not necessarily. It would depend on which one of the chemistries changed, in which direction it changed, how much it changed.

Q Are you saying that it would or would not then be significant, Doctor?

A It may or may not be.

Q But are there indications on a liver profile test that in order to be properly interpreted or to give you an optimum interpretation one would have to refer back to a prior liver function test?

A Yes, Mr. Dunn, although I don't have the prior one with me I can tell you there is very little difference. The chief difference is in the farthest column to the right, the bottom of which reads SGOT.

Q You say there was one liver profile test in the file?

A Pardon, Mr. Dunn?

Q Was there more than one liver profile test prior to the one that was taken last Thursday concerning Mr.

Diaz in the file?

A I don't have any more. I had the first one and I have the one that was taken Thursday.

Q You stated during your last testimony, Doctor, that, as I recall, you had some doubt as to the accuracy of the notations with respect to Mr. Diaz having abused alcohol because no liver function test had been ordered?

A Yes, that is true, Mr. Dunn.

What I meant to say was that when a methadone patient is suspected of having a drinking problem he is required to have a liver profile done every three months, and since Mr. Diaz didn't have a liver profile ordered every three months, I had to assume that the rest of the clinic did not agree with the nurse who made those notes.

Q If, in fact, Mr. Diaz had such a liver profile test performed, would that alter the opinion you have previously given with respect to his employability?

A If he had one performed every three months and that was orderedby the doctor, who is the only one who can order it, I would assume that the doctor and the clinic had reason to believe that Mr.Diaz had a drinking problem. In the absence of such an order by the doctor I would have to assume that Mr. Diaz does not have a serious drinking problem.

Q Did you in 1971, Doctor, have a counsellor by the name of C. Sher?

A Yes.

Q Is it Miss or Mrs. or Mr. Sher?

A It is Mrs.

Q Is she still employed by your program?

A I don't think so, Mr. Dunn, and I am not trying to be coy. The last time I saw her several months ago she was pregnant. I had a brief conversation with her, and she was talking about going to social work school. I have not seen her recently, but that does not mean thatshe is not still with us. I know that she is not in that clinic where Diaz is.

Q Did you have any reason to question the veracity of the notations that she made in the clinic records?

A Well, that is a big question, Mr. Dunn. I question the veracity of my own notes even these days --

Q As compared, Doctor, with the nurses you referred to earlier whom you found to be unsatisfactory?

A In a limited area I found her to be unsatisfactory. I am still trying to protect her reputation.

Q We appreciate that.

A I think that at the time Mrs. Sher worked in that clinic, as I recall she was relatively new. Now

you are asking me something that I really should be checking out. We have over 450 employees on a methadone program, and it is really very difficult for me to keep up with all of them. I happened to be better focussed on Miss Carson because I worked with her personally on several occasions.

Q When did Mrs. Sher, Doctor -- if I may interrupt -- come with the program?

A I have no idea. I would have to check personnel records.

THE COURT: Where does she appear? What is the significance of Mrs. Sher? What is the significance?

MR. DUNN: July, 1971, there is a behavorial note signed by Mrs. Sher.

THE COURT: Is this in evidence?

MR. DUNN: No. I will offer it, your Honor. I apologize for not offering it previously, your Honor.

(Defendant's Exhibit WW marked for identification.)

BY MR. DUNN:

Q Dr. Trigg, I show you Defendant's Exhibit WW and ask you if you recognize that as a Xerox copy of records maintained by the Beth Israel Methadone Program?

A It appears to me, Mr. Dunn.

MR. DUNN: I offer that in evidence, your Honor.

THE COURT: Any objection?

MR. BALBER: May we see it, your Honor?

MR. DUNN: Yes (handing).

MR. BALBER: No objection.

THE COURT: All right, that is received.

(Defendant's Exhibit WW for identification received in evidence.)

THE COURT: Are these part of a large Beth Israel record for Mr. Diaz?

MR. DUNN: They are, your Honor.

THE COURT: That overall record is not in evidence?

MR. DUNN: No, your Honor.

THE COURT: All right, go ahead.

BY MR. DUNN:

Q If a person uses alcohol excessively how soon does this use reveal itself in a liver profile test, if at all?

A Mr. Dunn, I am sure that there would be many arguments about that depending upon which physician you asked. I would set it at about a year after fairly heavy drinking; there should be some alterations. This is a very comprehensive test.

Q Is it possible for a person to drink excessively for a period of five years without having this reflected in the liver profile test?

A I would doubt it very, very seriously.

Q On what do you base that, Doctor?

A My experience in exactly what the liver profile measures.

Q What does it measure?

A I might point out that the only organ of the body that detoxifies poisons is the liver. There are no other organs, and the function of detoxifying anything taken in the system is not shared with any organ.

Alcohol, techcnically, is a poison, a toxin. So is just about anything, any drug, medication. Now that has got to be detoxified by the liver. If the individual was pouring an amount of toxin - that is, alcohol in this instance - which the liver has to detoxify, it is inconceivable that the liver would not reflect it in its functional capacity as measured by the liver profile. So I just done see how the liver could escape.

Q Can you say with medical certainty, Doctor, that the liver profile that you took last Thursday of Mr. Diaz is conclusive that Mr. Diaz in the past five years has not abused alcohol?

A In my opinion I would have to answer that yes, he has not abused alcohol on the basis of this liver profile.

Q Would this liver profile be consistent with an individual who in the last five years had been drinking six or seven shots of scotch an evening?

MR. BALBER: Objection, your Honor. There is no evidence as to that drinking.

THE COURT: Overruled.

THE WITNESS: I am sorry, your Honor?

THE COURT: Mr. Reporter, will you read the pending question.

(Pending question read as above recorded.)

A Would this liver profile be consistent? That is very difficult for me to answer, Mr. Dunn, in an informed way.

Q I am not, Doctor, suggesting that you give an answer that is inaccurate. If you don't know the answer --

A I think I have to say that I don't really know the answer, and what I am wrestling with is that individuals vary in their tolerance to drugs.

Now, that is one basic thing in medicine that just to be true and I can't avoid that.

The point I am trying to make is that if you

look at the liver profile the shaded areas are the normal areas. Now, several of these lines that the technician drew would have to be way above those shaded areas to be consistent with heavy alcohol consuption, and if you just look at them, the lines are not above except in the far right column, the SGOT which was also elevated in the original of the profile, and Mr. Diaz has a history of hepatitis, and it is perhaps that hepatitis that keeps the SGOT elevated. But you can't isolate the SGOT out of the 11 other chemistries.

If there were four markedly elevated chemistries, then I would say, well, yes, this is consistent with heavy drinking. But you have got one out of 11 and it is not that markedly elevated.

Q The liver profile test, Doctor, measures the functional capacity of the liver, does it not?

A Yes, sir.

Q As opposed to indicating whther or not a person has used or presently uses excessive amounts of the drug, alcohol?

A Not as opposed to, Mr. Dunn, because as I stated --

Q Does the liver function test --

MR. BALBER: Objection, your Honor. I request that the witness be permitted to answer the question.

THE COURT: Yes, let's let him answer it.

A As I stated, the liver is the organ, the sole organ which has to detoxify the alcohol. So if somebody is drinking heavily these days and the preceding three years, I don't see how it could not show up on the liver profile.

Q But would you say with medical certainty that it would show up, Dr. Trigg?

A Mr. Dunn, I don't think I could say anything with complete medical certainty.

Q Does methadone have an effect on the liver, Doctor, if you know?

A Methadone has no demonstrated effect on the liver as measured by the liver profile. That is not to say that methadone has no effect on the liver, since methadone is a toxin; it too is detoxified by the liver.

Q Have there been clinical tests performed that have been reported in medical journals that confirm your statement, Doctor?

A There have been clinical tests. I do not know if they appear in the literature.

Q I refer you, Doctor, to Defendant's Exhibit WW and ask that you read that portion starting July, 1971.

A "July, 1971.

"Patient continues on once-a-week schedule;

no drug abuse; still works for Telesonic Corporation; lives with wife and three children. Have discussed patient's drinking with him as to whether it is a problem" -- the word "problem" is underscored -- "or not. He was quite open and honest about it. He says he drinks beer a couple of times a week with the guys from work and never considered it a problem.

"We discussed it at length, and he said if it was harming him physically he wanted to know about it.

"He had liver function tests taken. Since we have not heard from them we assume he is in good condition.

"His reaction made me feel that even if he were drinking too much, by talking about it and making him aware of the dangers it would be enough to make him stop."

THE COURT: What is the date of that, please?

MR.DUNN: July, 1971, your Honor.

THE WITNESS: Did you want me to read this whole note?

Q Yes.

A I didn't finish.

"Patient still interested in Transit Authority. I am holding him in Phase 2,since there may be some headway in this area.

"Patient continues to do well, and minimal

counselling to help patient vent his feelings is necessary only."

The grammar is kind of bad.

Q Is there a signature at the end of this behavioral note, and, if so, will you read it?

A The signature is C. Sher.

Q This is the same Mrs. Sher to whom you referred in earlier testimony today?

A Yes, sir.

Q I show you Defendants' ExhibitXX for identificatio and ask you if this is a record of Beth Israel medical center referring to Francisco Diaz?

A It appears to me to be so, Mr. Dunn.

MR. DUNN: I offer it.

MR. BARBER: I have not seen it. No objection.

THE COURT: No objection? XX is received.

(Defendants' Exhibit XX received in evidence.)

Q I hand you Defendants' Exhibit XX, Doctor, and ask if you can tell me what this form is.'

A It is a consultation request and report.

Q Can you read for me the consultant's report, the second half of the form?

THE COURT: What is the date?

THE WITNESS: The date of the consultant's report is 4/30/73.

THE COURT: Whom does it relate to?

THE WITNESS: It relates to Francisco Diaz. It

appears to be a doctor's writing, because I am having tremendous difficulty reading it.

THE COURT: Have you studied it, Mr. Dunn?

MR. DUNN: I have.

THE COURT: Can you read it?

THE WITNESS: I can read certain words.

MISS DuBOIS: One of our problems in admitting it is it is illegible.

MR. DUNN: We have never been given the original records from Beth Israel.

THE COURT: I just can't waste time. If you can read it, read it subject to correction. I assume you have studied it.

MR. DUNN: I have, your Honor.

THE COURT: What is your reading of it?

MR. DUNN: The portion I would like to read is contained in the part labeled Consultant's Report:

"For past five years patient has been drinking six to seven shots of scotch."

MR. BALBER: Your Honor, it does not indicate whether that is once a day, once a month, or once a year, and unless it can be clarified we request that that portion of the document be excluded from evidence.

THE COURT: How often?

MR. DUNN: It says for the past five years.

THE COURT: Who signed this?

THE WITNESS: Your Honor, I can't even identify the signature.

MR. DUNN: It purports to be a physician at Beth Israel. It is a signature followed by the initials MD on a Beth Israel form.

THE WITNESS: I just can't make out the name.

MR. DUNN: May we have the original?

THE COURT: Is the original going to be any better than this?

THE WITNESS: No, your Honor, this is a Xerox.

MR. DUNN: We found the quality extremely poor.

THE WITNESS: It's not the quality of the Xerox that I'm having trouble with, it's the doctor's writing.

MR. DUNN: Perhaps we can show that to the doctor.

THE WITNESS: I was looking down at the bottom to see what conclusion the consultant came to.

MR. DUNN: I am interested in his observation, Doctor, about the six or seven scotches.

THE COURT: Well, I don't know that the original would do any better than this.

MR. DUNN: I think if the doctor has access to it it wouldn't take very long.

THE COURT: We were going through one set of records with Dr. Trigg when he was here before. Couldn't we have gone through the whole set of records?

MR. DUNN: Dr. Trigg made certain statements when he testified previously that led me to introduce certain documents. I had not been aware that Dr. Trigg was going to make those statements after examining the record. I find additional items that apply to the statements made by Dr. Trigg.

THE COURT: Are we going to have Dr. Trigg come back again because he might find the original record but may say something more than this does?

MR. DUNN: It goes to the very heart of the case.

THE COURT: If it was at the heart of the case why didn't you read it to him when he was here a few weeks ago?

MR. DUNN: Because I was taken by surprise. I had no indication as to the testimony he was going to give about Mr. Diaz.

THE COURT: Did you have his record?

MR. DUNN: Yes.

THE COURT: I doubt very much if the original has anything much clearer than what is here, and it is up to you to pursue it. If you want to pursue it with Beth Israel

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or try to subpoena the doctor who wrote that, that is up to you, and we will see what happens.

MR. DUNN: I would like the opportunity at least to talk to the doctor.

THE COURT: We don't know his name right now. So you take that up with Beth Israel.

Let's suppose somebody was taking five or six shots of scotch per day, how would you regard that as far as the degree of drinking?

THE WITNESS: Every night? I would consider the individual a problem drinker. But again, your Honor, I have to get back to the statements that I have made that if the clinic really feels that he is a problem drinker, they are required to do a liver profile every three months, and he just doesn't have liver profiles every three months.

THE COURT: Well, if you got a doctor's record in there that you can't read, maybe nobody knew what it was saying. That is the thing.

THE WITNESS: I think, your Honor, in the course of normal operations the nurse in the clinic reads any serious note to the clinic over the phone. Since the medical clinic from which that record emanates, at least, the consultant's report, is located within Bernstein Institute, and none of the clinics are, also, it would have been incumbent upon

the doctor to answer that consultation to do the medical treatment, since the medical treatment is not done in the outlying clinics.

THE COURT: What did he mean, the doctor who answered that?

THE WITNESS: The doctor who answered that is a physician, an internist.

THE COURT: Answered what?

THE WITNESS: The consultation request.

THE COURT: I don't understand.

THE WITNESS: The second half of that sheet.

THE COURT: Is that a request by somebody?

THE WITNESS: The top half is the request.

THE COURT: What is that request?

THE WITNESS: For a consultant to examine the patient. The bottom half of the sheet is the consultant's report.

THE COURT: Who made the request at the time?

THE WITNESS: I believe that it was one of the doctors in the clinic. I saw a Dr. Doshi's name on there. I think it is Dr. Doshi.

MR. DUNN: What name follows Dr. Doshi?

THE COURT: What is the doctor's name?

THE WITNESS: Dr. Doshi.

THE COURT: And where is he located?

THE WITNESS: He is a psychiatrist who runs one of the methadone clinics at Beth Israel.

THE COURT: He made a request to whom?

THE WITNESS: Well, I am not sure he made the request. This consultation has a slash mark after his name and a nurse's name afterward. So apparently she wrote out the request, which is not unusual.

MR. DUNN: May I have the nurse identified?

THE WITNESS: I am not sure that I can get her name. E appears to be the first initial.

Q Is it Walker?

A I can't tell whether it is Walker or Walco. It could be Walker. I could get it identified.

THE COURT: So somebody, whoever it was, the nurse or the doctor, requested a consultation?

THE WITNESS: Requested a consultation.

THE COURT: To the central office or whatever?

THE WITNESS: To the medical clinic, which is located in Bernstein. It is located in a health center at 25th Street and First Avenue. So that on April 24, 1973, the clinic requested the consultation. The consultant apparently examined the patient and wrote the note which we are having trouble reading on April 20, 1973.

My point is that the consultant who answered that would have had to provide treatment if he found something wrong. Not the psychiatrist in the clinic who initiated the consultation. It would have been up to the consultant to follow through, even if it required hospitalization.

* * *

E L A I N E F L O W E R S, called as a witness on behalf of the plaintiffs, being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. BALBER:

Q Miss Flowers, what professional training have you had?

A I am a Registered Nurse.

I was trained at Manhattan State Hospital School of Nursing, and I also attend Long Island University.

Q What is your current position of employment?

A I had head nurse at Beth Israel, 25th Street and First Avenue, methadone maintenance treatment program.

Q How long have you held that position?

A Three years. It will be four years this October.

Q How long have you been stationed at that particular clinic?

A It was a year last November.

Q So you have been stationed at that clinic since November of 1973?

A Yes.

Q Francisco Diaz enrolled as a patient in that particular clinic?

A Yes, he is.

Q Has he been enrolled as a patient in that clinic during that entire period of your service there?

A Yes.

Q Can you please describe briefly what your professional nursing experience was before you took your current position?

A I worked at Manhattan State Hospital in psychiatry for three years. I worked at NYU - New York University Hospital in neurology prior to that.

I aorked in business for the Publishers Guild for a year.

Q Can you describe briefly the duties of the nursing staff that you head at the clinic, the things that you do on a day-to-day basis with regard to patients?

A The duties and functions vary. In my particular

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clinic I supervise the administration of methadone.

Q That means you hand out dosages?

A Yes.

Q And how are they handed out?

A They are handed out in bottles. We are still on disket, and nurse No. 1 checks the dose that is sent by the pharmacy in the bottle to see if it is correct.

Q To make it corresponds with what a particular patient is supposed to be getting?

A Yes. We mix the medication with water and then give it to the patient.

Q So the disket is dissolved in water?

A Yes.

THE COURT: How do you spell it?

THE WITNESS: D-i-s-k-e-t.

THE COURT: What is a disket?

THE WITNESS: It is one of the forms that methadone comes in.

THE COURT: Physically what is it?

THE WITNESS: It is a little orange pill.

Q Now, do you say you dissolve it in water?

A Yes.

Q Is it in a bottle?

A It is in a bottle. We check the dosages that the patient has to go home.

Q Are those in separate bottles?

A Yes. We also have a form of liquid methadone that we also dispense at the same time to certain patients.

Q But if the patient gets it, sometimes it is in biscuit form and sometimes it is in liquid form?

A Yes.

THE COURT: The people that are getting the biscuits, they will either have it dissolved in water and drink it, or else they will have it dissolved in water and the liquid solution home with them?

THE WITNESS: Yes.

Q Can you go on describing what the nursing staff does?

A We are also responsible for the physical condition of the patients, if they have any physical problems whatsoever. We have diabetic patients, for example. We check the vital signs, the pulse, before we administer their cardiac medicine. We also have patients with varying physical illnesses, hypertensive, and we check the blood pressure. If a patient

has any physical complaint, we check it.

Q The patients that you just described, these are people with non-chronic medical problems?

A Yes.

Q You don't check the blood pressure with everyone?

A Vital signs are checked now every three months.

Q So everyone gets checked every three months?

A Yes.

Q How often do the chronic patients get checked?

A Once a week by the nursing staff.

Q Now, what do you do if a patient has an acute medical problem?

A I, number 1, will try to find out the complaint. If the patient requires immediate hospitalization, a nurse and a counselor will accompany the patient to the emergency room, either at Bellevue Hospital, since it is right across the street from the clinic, or if it is not severe, we take the patient in a taxi to the Beth Israel medical clinic.

Q If the patient comes in and says, "I have a cold."

A We check their temperature, pulse and respiration. If they have an elevated temperature, we call the medical clinic and have the patient seen that day at that clinic.

Q If he has a stomach ache?

A Yes, we ask him first, "What did you eat?" Did you

eat your breakfast?" That is the most important point. They have to eat their breakfasts before they take their medicine.

Q Now, what do you do if the patient is very sick? You take him to the emergency room?

A Yes.

Q What if he is not very sick, just somewhat sick?

A If it is a complaint that is not a matter of life and death, we call up the medical clinic and make an appointment for the patient to be seen by the doctor. Plus some patients do have their private physicians. The patient says, "I am going to my private doctor." We ask the patient to bring a note from the doctor stating the treatment he has given him.plus the medication, because some medications are not compatible with methadone.

Q Now, you described the dispensing of medication and you talk about patients with medical complaints. What do you do?'

A We observe the patients chiefly as to consciousness, alertness, responsiveness. We also have health teaching and they participate with the community.

Q What is health teaching?

A For example, a lady is pregnant and she has come in and she has not kept her pre-natal clinic appointments.

So we go into that, find out what has been happening with her, why she has not kept her pre-natal clinic appointments. Health teaching also is in the area where some of our patients do not eat their meals properly. We sit down and talk and ask them, "What did you have for breakfast, lunch or dinner yesterday?" Either too many carbohydrates or something else, and we give them a regular diet that is well balanced so they can retain their proper health.

Q What else do you do?

A I personally run two groups. One is with obese patients and the other is for patients that have alcohol problems.

Q What goes on with these groups?

A In the group for obese patients, we meet every Thursday night from 5:30 to 6:30, and the first part of the program just consists of calisthenics and a half hour jogging, and the second half of the program is sitting down and talking with them.

Q What goes on so far as those on alcohol?

A We have alcoholics anonymous, and we refer some of them to Alcohol Anonymous, and if necessary I go with them to a meeting. I ask them during the week, "Have you gone to the meeting?" And we have literature that they need for everyday help, and I know which patients are in Alcohol

Anonymous, and they come in and do their daily readings there.

Q How do you discover has a drinking problem?

A You can, for one, smell it on his breath, and, number 2, we have staff meetings, twice a week, we have incident meetings every week, and either the counselor or the nurse or someone on the clinic staff has observed the problem and brings it up for discussion.

Q What is an incident meeting?

A An incident meeting is where we go over problems that arise, and any time it is not scheduled for like a regular staff meeting day, we just have staff meetings like twice a week where the whole staff is present.

Q Now, do you follow a routine procedure when the staff determines that a patient has an alcohol problem at one of these meetings?

A Yes, it is not routine. It depends on how much the problem is. Usually, however, if the patient has a problem, they usually suggest that the patient does go to Bernstein Hospital and detoxify from the alcohol.

Q By the way, in addition to all these other functions do nurses do counseling?

A Yes, we do..

Q During your service at 25th Street?

A Yes.

Q At the 25th Street clinic have you had an opportunity to observe Francisco Diaz?

A Yes, I usually see him like once a week.

Q In what context do you see him?

A When he comes to the clinic for his medication I am usually in the nurses' station when he arrives. I am not the one who medicates him on all those occasions.

Q Do you have the opportunity to observe his physical appearance?

A Yes.

Q To smell his breath?

A Yes.

Q And you said this arises about once a week?

A Yes.

Q From your observations have you ever had reason to suspect Mr. Diaz has been intoxicated at the clinic or have a drinking problem?

A No.

Q Can you generally describe Mr. Diaz's deportment while he is at the clinic?

A He appears alert and responsive and in contact.

Q Does he hang around? Does he congregate with other patients?

A Not generally. He comes to his counselor and he talks to the nurses and leaves.

Q Is he disruptive?

A Never.

Q Does he attend regularly?

A Usually.

Q And usually when he does not attend regularly do you know why?

A He works up in Yonkers. At the times he has not come into the clinic he has called up the clinic and said, "I will not be able to be in tonight and I possibly can't be there before 11 o'clock."

Q What happens in those instances?

A If he calls, for example, before 3:30 we will leave the medication down at Bernstein and he goes down there and picks it up. If a patient is unable to get there before 11 o'clock there is no place to receive the medication. And he comes in the next day and he has no physical discomfort, because methadone is a long acting drug. He goes through no withdrawals whatever if he misses one day's medication.

Q How closely has Mr. Diaz adhered to clinic rules and regulations?

A To my knowledge he has not violated any of them.

THE COURT: I think we better adjourn now until 2:15.

MR. BALBER: This will be very short.

MR. DUNN: There is cross-examination.

MR. BALBER: I can finish up in five or ten mirutes.

THE COURT: No, I have another meeting, so we will adjourn until 2:15.

(Recess to 2:15 P.M.)

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AFTERNOON SESSION

2.35

ELAINE FLOWERS, resumed.

DIRECT EXAMINATION CONTINUED

BY MR. BALBER:

Q Miss Flowers, I would like to show you a form marked Consultation Request and Report. It has been previously marked as Defendant's Exhibit XX in evidence. Are you familiar with that form and how it is utilized in the treatment program?

A Yes. It is a consultation form that the nurses send over to the medical clinic or the emergency room or wherever the patient is referred to. This one was sent to the medical clinic.

Q You indicated previously in your testimony that when a patient has a medical problem you refer him to the center when you think he has one. Is that one of the forms used?

A Yes.

Q Who fills out the top-half of it?

A The nurse at the clinic.

Q What is she supposed to report in that part of the form?

A Just her observations, what the nursery did.

lp2 Flowers-direct

Q Now, looking at that form, based on your experience can you tell the Court why that form was filled out or what the nurse's request was when she filled out that form?

MR. DUNN: Objection, your Honor.

THE COURT: I didn't hear the question.

(Question read.)

THE COURT: Overruled.

Q Will you answer the question?

A I can just read what she has written here.

It says: "Patient appears to have yellowing of sclera of eyes. On methadone, 100 milligrams.

"Patient states that he has not had a physical lately."

So she was just using her judgment. One of the systems of some major illnesses is yellowing of the eyes, and the patient did not have a physical lately. So she was requesting to find out, No. 1, why the patient's eyes were yellow, and, No. 2, to have a physical exam done on the patient.

Q In your nursing experience, of what would you think it was symptomatic that the patient had yellow eyes?

MR. DUNN: Objection, your Honor. The witness not qualified as a physician.

MR. BALBER: I said her nursing experience.

lp3 Flowers-direct

THE COURT: Overruled.

A It could be a symptom of cirrhosis of the liver or liver disease.

Q It could also be a symptom of hepatisis?

A Yes.

Q Now, on the second half of that form - who completes the second half of that form?

A The bottom half was completed by a doctor.

Q Now, Dr. Trigg tried to read that bottom half and had some problems with it. Can you read it?

A Yes. "Consultation report. Complaint: Chief complaint was a yellowish discoloration of the eyes." It says: "Patient has no history of dark urine or light stools."

Q What is dark urine a symptom of?

A Of hepatitis or cirrhosis of the liver.

Q And what are dark stools a symptom of?

A The bile would be excreted in the stool, and also the patient's stools also would be dark if he had hepatitis.

MR. DUNN: Your Honor, I again object on the ground that the witness is not competent to testify to the symptomatology of disease.

THE COURT: Overruled.

lp4 Flowers direct

Q Please continue with the form.

THE COURT: So those remarks would indicate the absence of a liver problem, right?

THE WITNESS: Right.

And it says -- I have difficulty reading it -- it says: "For the past five" -- something -- "patient has been drinking six to seven shots of scotch." And then it has a period.

"Possible diagnosis: Ictious sclera."

Q What does that mean in plain English?

A It means yellowish eyes.

Q Continue, please.

A "Slight congestant in the throat; chest clear; heart" -- I cannot read the letters after "heart."

"Liver dullness 4, 1 to 2 centimeters.

"Abdomen felt."

The next word I cannot translate. I wouldn't know -- oh, "Abdomen felt because patient keeps tensing up abdominal walls."

Q I would like to direct your attention specifically to a notation on the left-hand corner of the form. There is AR/ and AO, and the word written after that.

A That means rule out cirrhosis of the liver.

Q And cirrhosis is a symptom of chronic drinking?

A Yes, it is.

THE COURT: This is on what exhibit?

MR. BALBER: XX.

Q You described the nursing function in the clinic and the nursing services, as well as the two groups that you run for alcoholic patients and dieting patients. Can you describe what staff in addition to nurses and counselors are present?

A There is the psychiatrist, who is a doctor, a psychiatrist assigned to the clinic; there is a social worker full time.

Q What does the social worker do?

A Sees the patients if they have any difficulty, for court cases sometimes; sometimes the social worker does family therapy. She does in our clinic. And she also makes referrals, for example, if our patients have to have a referral to a nursing home, she does the background work on that. Also, patients who are pregnant, the social worker sees the pregnant patients before delivery

and after delivery and will follow up on the baby.

Q In addition to the social work, do you have anybody else?

A We have a part-time rehabilitation worker. We also have counselors and we also have research assistants who are ex-addicts, who are on the methadone program that do counseling. Besides, there are three nurses, including myself, and two secretaries.

Q Now, in addition to the medical and nursing services and counseling services and so forth provided by these persons, are there additional services made available to the patients at some location other than your clinic? Are there backup services?

A Yes, we have the hospital facilities of Beth Israel Hospital at our disposal.

Q What kind of things are done there?

A They have a comprehensive health service care and they have the clinic for children. If any of our patients have children that have any difficulty, they have a new comprehensive health service. It means that the patient is seen by one doctor and one nurse, and they see the same physician each time they go to the clinic with a complaint.

There is also the dental clinic which is in Beth

Israel.

One of our patients had cancer and received the diagnosis, for example, at Beth Israel. He had the complete workup by the hospital. He received radiation treatments for his cancer while he was there, and in the interim he could not go back home because he had a shortness of breath and a three-floor walkup. So the social worker arranged for a transfer for this patient to Calvary Hospital.

Q You described earlier two group activities that go on in the clinic. Are there any other activities that go on?

A Yes, there is one group that is held on Thursday night for patients that are on slow dose reduction. All those patients are required by the staff to attend this group and it is run by a counselor and a former drug addict.

Q What goes on in this group?

A This is for patients who start on 100 milligrams of methadone and the dose is lowered 10 milligrams per month usually to get them off methadone, and they have found that the group is very supportive for some of the psychological changes that the patients do go through at times when they are coming off methadone. It is important for supportive treatment. And there is also a group, an arts and crafts group

for the female patients that are in the clinic, sewing, knitting and crocheting.

There is also a photography group that meets once a week, patients who have 35 mm. cameras. One of the counselors is an ex-photographer, and there are patients that participate in this group.

Q Is there any general group counseling?

A Yes, that is being done by the social worker and they set up short term groups. For some patients coming out of Bernstein for detoxification, they have a group for one or two months, and then dissolve. There are ongoing groups.

And the singing group -- I forgot about that-- there is a singing group which was formed by people that used to be interested in that until they got in drugs, and it is a form of rehabilitation. People are vocalizing and verbalizing, and they found the groups were good means to participate in something that was in the clinic and then to transfer that participation home to your own social life.

MR. BALBER: That concludes our direct.

THE COURT: Cross-examination, Mr. Dunn.

MR. DUNN: Your Honor, I ask that the court direct the production of the medical records of Francisco Diaz by

mmh5 Flowers-

the Beth Israel program. The witness this morning was testifying as to records concerning Mr. Diaz, which records have never been produced, were not produced as a result of your Honor's prior order because the records came into being after your Honor's original order, and we find that it is difficult, if not impossible, to cross-examine this witness as to comments she has made regarding records we have never seen.

THE COURT: I have a verdict in the other case, if you will excuse me.

(Recess)

MR. DUNN: Shall I have the reporter read the question I made to the court just prior to the recess?

(Record)

THE COURT: What are the records?

MR. DUNN: Miss Flowers referred to absences or the missing of medication by Mr. Diaz and offered an explanation. What we have not seen are the records which Miss Flowers refers to in this particular program since November of 1973. We don't have the records beyond September of 1973, your Honor.

MR. BALBER: Miss Flowers has been kind enough to bring all her records with respect to Francisco Diaz, which I gave to Mr. Dunn.

mmh6

MR. DUNN: Some notes are being looked at by my associates. They represent nurses' notes. We would like the medical notes, the doctor's notes, the behavioral notes. Also, XX was somewhat illegible. It was the consultation sheet that the witness testified to and Dr. Trigg testified to. We also request the original of this document be produced.

THE COURT: Did you ask on a prior occasion for all the Beth Israel records regarding Mr. Diaz?

MR. DUNN: Yes, your Honor, we had.

THE COURT: Did you get a group of records?

MR. DUNN: We received a group of records, the latest of which is dated in the fall of '73.

THE COURT: When did you get those?

MR. DUNN: About a year ago. It was under your Honor's order.

THE COURT: Did you make any other request?

MR. DUNN: We didn't know that the witness was going to testify as to events that took place after the date that we received the records.

THE COURT: You would be entitled to every scrap of paper that Beth Israel has about Diaz. But the question is, to be demanding it right now when we are really trying to finish up this trial is a little late. Now, there was

not any matter of surprise about somebody testifying. I would assume you would want everything that Beth Israel has got about the plaintiff from start to finish. We didn't start this trial until October. Isn't Diaz still a patient there?

MR. DUNN: Yes.

THE COURT: You knew he is still a patient. Now, if you get records going through the fall of '73 I wonder why you didn't ask for those beyond that before this very moment?

MR. DUNN: Because they were not put in issue until Miss Flowers testified that Mr. Diaz had this medication frequently and then offered an explanation. Until that point they were not really in issue.

THE COURT: The records of Diaz have been important from the moment this case started. You went through those records with Dr. Trigg before and you found out some things you wanted to cross-examine Dr. Trigg about. Apparently you went through them again and you found some other things you wanted. The records have been important from the minute this case started, and that is why you asked for them. Now, apparently, Beth Israel won't keep supplying you records on an updated basis. They didn't really need to. And you now ask for all the records. What are we going to? Are

mmh8

we going to have this with the other people?

MR. DUNN: I don't anticipate, no. What I request, your Honor, very respectfully, if Beth Israel can be directed to make the records available. I would like to look at the original records. I will do it one day this week. I understand we resume again Friday. I will be prepared on Friday to proceed with the cross-examination of the witness.

MR. BALBER: At some point this thing of dragging witnesses back because of their negligence should be stopped.

THE COURT: That does not come with any grace at all from your mouth. You need not go into that.

What other records would the Beth Israel have and where would they be, since apparently there were some records presented as of the fall of '73 some date, and then there must be other records? Right?

THE WITNESS: Yes.

THE COURT: Would they be at your place?

THE WITNESS: I turned them over to Dr. Trigg. Our office turned them over to Dr. Trigg last week.

THE COURT: So he has the records?

THE WITNESS: Yes.

THE COURT: How big a bunch of records are they?

THE WITNESS: It is records like from November of

mmh9

'73 to January 1st, '75.

THE COURT: What volume would they be?

THE WITNESS: It is like six sheets of medication and just two sheets of nurses' notes.

THE COURT: I am going to direct that those records be made available on the same basis I made them available before. I'm not going to direct this witness to come back. You can look at the records between now and Friday, and if you need any further testimony we will talk about that Friday. It may not have anything pertinent or it may be something you can simply read in, because a lot of this has just been reading in. You don't have to have a witness on the stand to do that. So you continue with your cross-examination of Miss Flowers.

MR. DUNN: Do I understand that the court directs that the original be made available for inspection?

THE COURT: What is the point of the original. She has read it.

MR. DUNN: But she was unable to read a part of it, as was Dr. Trigg.

THE COURT: Can we get the original of XX?

THE WITNESS: If it is a matter of handwriting it's not going to be more legible.

THE COURT: Produce XX.

MR. DUNN: Now these are to be examined at Dr. Trigg's office?

THE COURT: That is an arrangement that can be made. Certainly by now you can find out where to examine the records.

Okay.

CROSS EXAMINATION

BY MR. DUNN:

Q Is it Miss Flowers or Mrs. Flowers?

A Miss.

Q Miss Flowers, you testified that it was important for a methadone patient to eat breakfast before taking methadone, is that correct?

A Yes.

Q Why is it important for a methadone patient to have ingested breakfast before taking methadone?

A Because it irritates the stomach and you should have some protein in your stomach; otherwise you can wind up with a gastric ulcer if you continue to drink methadone without eating your breakfast. For an extended period of time you can develop gastroenteritis or an upset stomach.

Q On what do you base that?

A What do I base that on?

Q Yes.

A On facts that were told to me by doctors, and we include this as part of our patient teaching.

Q I show you Defendant's Exhibit BBB and ask you if you can identify the handwriting and the signature that appears after the date October, 1973?

A Yes, I can -- will you state that question again, please?

Q Can you identify the handwriting and the signature?

A Yes, I can.

Q Will you identify the individual who is responsible for having made the entry, please?

A Ellen Volko, the nurse that was at the clinic before I arrived.

Q Where is Miss Volko employed now, if you know?

A She is still employed by the program. I think she is working in St. Clare's OPD.

Q I show you Defendant's Exhibit XX and ask you if you can identify the name of the physician whose name appears as being the author of the Consultants' Report?

A No, I cannot tell you which doctor signed this.

Q Can you identify the nurse?

A Yes. Ellen Volko.

Q Do you know what the significance of the liver dullness is?

lp3 Flowers-cross

A Do I know what the significance of liver dullness is?

Q Yes.

A No, I do not.

Q On the consultative report does the doctor observe a liver dullness of patient Diaz?

A Yes, and also noted --

Q Is this symptomatic, Nurse Flowers, of liver disfunction?

MR. BALBER: Objection.

THE COURT: Overruled.

MR. BALBER: Your Honor, the witness has stated she doesn't know what liver dullness means, so how can she answer?

THE COURT: This is cross-examination.

Objection overruled.

A Usually in liver damage the liver is increased in size. It happens in the case of cirrhosis and it happens in the case of hepatitis.

Q What does liver dullness mean?

A That was this physician's term for describing what he observed of the patient's liver, but I can't interpret and tell you --

Q Would this be palpably observed?

lp4 Flowers-cross

A Usually, but it says that the patient keeps tensing abdominal walls, so he couldn't even complete the examination properly.

Q I ask you again, is liver dullness symptomatic of liver disfunction?

A I don't know.

Q Had you ever seen Francisco Diaz prior to November, 1973?

A No, I had not -- I might have, however, but I don't recall to my knowledge meeting him.

MR. DUNN: May I have this marked for identification as Defendant's Exhibit CCC.

(Defendant's Exhibit CCC marked for identification.)

MR. DUNN: Will you mark these as Defendant's Exhibits DDD and EEE for identification.

(Defendant's Exhibits DDD and EEE marked for identification.)

BY MR. DUNN:

Q Nurse Flowers, I show you Defendant's Exhibit CCC for identification and ask you if you can recognize that as the record maintained by the Beth Israel Medical Program referring to Francisco Diaz?

A Yes, it is.

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MR. DUNN: I offer it, your Honor.

MR. BALBER: No objection.

THE COURT: Received.

(Defendant's Exhibit CCC for identification received in evidence.)

MR. DUNN: I hand the witness Defendant's Exhibit CCC and invite her attention to a notation made November 13, 1973. I request that the witness read it to us and identify the author.

THE WITNESS: November 13?

Q Yes, ma'am.

A "11/13/73. No apparent signs of alcohol abuse."

It is signed by me, Elaine Flowers.

Q Was there some reason that you were looking for alcohol abuse at that time, Nurse Flowers?

A Only because of the two previous notes that I had seen written by the nurse that is up here.

Q What were the two previous notes?

A "October, 1973. Patient appears neat and clean. Still question of abuse of alcohol."

Q Who had signed that?

A E. Volko.

Q And the note preceding that? Would you read that for us, please?

A Yes. This is September, 1973.

"Patient attends regularly without complaints. Apparently doing well on 90 milligrams. Question of alcohol abuse, since patient is not obvious. Patient has history of drinking in past. Patient apparently not working."

Q Do you know Nurse Volko?

A I met her during my orientation at 25th and First when I was on orientation for that clinic.

Q When was that?

A In October of 1973 -- not October. November. I had seen her previously in the morning. We all ride the jitney to work or returning. At the end of the day the jitney picks us up and takes us back.

Q And is there a note dated March 4, 1974?

A 3/4/74.

Q Will you read the note to us and identify the author?

A It says: "No alcohol noted on breath. Appears alert and responsive."

Signed "E. Flowers." Myself.

Q And this note, too, or the reference to alcohol in this note was the result of having read Nurse Volko's --

A No, it is a matter of my observations of the

lp7 Flowers-cross

patient.

Q Do you generally make a notation with respect to alcohol?

A Yes, or drug abuse. We do negative charting, for example. If we do not observe any of those things I write, myself, "None," or "No," or "No apparent."

Q Did you discuss Francisco Diaz's case or record with anyone before coming here today?

A Yes, I did.

Q With whom?

A With the lawyer -- I think the lawyer at the first table there (indicating).

Q You refer to an alcohol program or a program for alcoholics at Beth Israel.

Will you tell me when that program first came into being?

A You mean the alcoholic unit that is presently there now?

Q Yes.

A The Alcohol Unit that was set up by Dr. Bahari is relatively new. It has just been there for the last one or two years. However, Beth Israel Hospital has been detoxifying alcoholics on the regular detoxifying program for years. I think it has been their function for six years.

Q Has alcoholism been a problem in the methadone program?

A I don't know if it is any more a problem in the methadone program than if you take any City blocks, you will find X number of alcoholics, X number of compulsive overeaters and X number of gamblers.

I just think if you take a certain population, a certain segment, you will find certain problems.

Q What percentage of the general population are alcoholics?

A I couldn't tell you.

Q What percentage of the persons in the methadone program at Beth Israel participate in the alcoholism program?

A In our clinic -- I can just testify to that, I am not familiar with statistics of the whole program -- but we have currently five patients in our clinic out of 500 patients that are in Alcoholics Anonymous.

Q So the entire alcohol clinic is composed of how many patients?

A I didn't say the entire alcohol clinic. I just said that -- and I cannot speak for the whole program; I can just tell you what I see in my clinic -- the census is approximately 200 patients, and of that 200 patients we have five patients in our clinic that attend Alcoholics Anonymous.

THE COURT: Wait a minute.

How many? The figure you just gave was 200?

THE WITNESS: That is number of patients at 21st and Fifth Avenue.

THE COURT: So it is five out of 200?

THE WITNESS: Yes.

THE COURT: Thank you.

Anything else, Mr. Dunn?

BY MR. DUNN:

Q How many days a week is the methadone program open?

A Our clinic is open Monday through Friday plus when the clinic is closed we take the methadone from our clinic for late pickup. The patients can pick up the methadone to 11.00 p.m. each night and also on Saturday they have a Saturday clinic which is from 8.30 to 3.30, and, if necessary, on Sunday there are arrangements made.

So even though our clinic is not open seven days a week the patients can receive the methadone seven days.

They also have an early a.m. pickup clinic for patients who are working and who have to be at work at 7.30, and they have at Bernstein's, and on occasions the patients can go there.

MR. DUNN: I have nothing further of this witness.

your Honor.

We do intend to call Ellen Volko, the nurse who had made the entries in the original.

THE COURT: All right.

Anything else for this witness?

MR. BALBER: One additional question.

REDIRECT EXAMINATION

BY MR. BALBER:

Q Nurse Flowers, how often does Francisco Diaz pick up his methadone?

A Twice a week.

Q That's the minimum allowed under your clinic regulations?

A Yes.

Q Is it the clinic policy to allow patients to pick up methadone if the clinic suspects a drinking problem?

A No. They would be based on a daily pickup schedule.

MR. BALBER: That is all.

THE COURT: All right, thank you.

(Witness excused.)

* * *

B R E N D A B R O W N, a witness called on behalf of the plaintiffs, being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. BALBER:

Q Miss Brown, what is your position of employment?

A Counselor at Beth Israel.

Q The Beth Israel methadone maintenance treatment program?

A Yes.

Q What station?

A 25th Street OPD.

THE COURT: What does OPD mean?

THE WITNESS: Out-patient department.

Q How long have you been stationed there?

A Two and a half years.

Q Is Francisco Diaz enrolled as a patient at that clinic?

A Yes, he is.

Q Miss Brown, can you describe what services you as a counselor provide patients as part of your regular duties?

A Well, it is a total rehabilitation from street life to society.

Q Let's see if we can be more specific. Do you have anything to do with the further education of the patients?

A Yes.

Q What do you do?

A The Board of Education has a high school equivalency course in which they can finish, the ones who did not have a high school diploma. We have a vocational rehabilitation department which also opens up trade schools for those interested in that.

Q Do you refer patients to these facilities?

A Yes, sir.

Q Do you deal with welfare problems?

A Yes. Sometimes we take patients to the welfare offices if they are having a lot of trouble. When they come to us undomiciled we take them to the Welfare Department and help them.

Q Do you engage in any family counseling?

A Yes, we engage in everything, every kind of daily living with each patient.

Q Do you get involved at all with patients' medical problems?

A Yes, we have a staff of three nurses and we have access to the medical clinic at Bernstein Institute that

treat our patients on methadone for whatever ailment they may have or complain of.

Q Are there procedures in your clinic by which you are informed whether persons whom you counsel are using drugs?

A Well, the nurses see all the patients when they come in. I see my patients on a regular basis. I don't see all of them every day.

Q How often on the average do you see your patients?

A Once or twice a week each.

Q Does the frequency correspond in any way to the needs of the particular patient?

A Of course, depending if they are having a problem at the time that requires us seeing them every day.

Q Can you describe what procedure you follow when you have reason to believe a patient is abusing drugs?

A Well, there are two ways: One is through your clinical observation by the nurse, counselor, staff; another is by urinalysis, and usually you know when a patient is abusing because they come in and the pupils are dilated, or their affect is inappropriate, they seem high, and if this happens often we feel that a person is addicted to some kind of drug, that they are abusing it somehow.

Q What if they are addicted to some kind of drug,

what do you do?

A Sometime before that they see our clinic doctor, and the staff and doctor consult and decide whether or not he should go into the hospital for detoxification of whatever drug he is abusing.

Q Not all patients abuse other drugs, are addicted to them?

A No.

Q What do you do when a patient shows intermittent abuse?

A We try to find out what the problem is. Someone comes in and seems high when they have a problem. We bring them in immediately and ask them are they high, what they are high from and why they are high. Sometimes it is disappointment. This is the way they face the problem. Sometimes it's the way they have been used to facing their problem, and we talk to them and try to teach them another way to face it.

Q When a patient is evidencing drug abuse does this have any effect on his clinic stay?

A Yes, we feel if a patient is abusing a drug we will put him on a daily visit, if he is not already on such, so he can be observed by the staff. We feel that he is probably addicted to it if he comes in there high or is

asking for some kind of help from us.

Q Now, you stated that you counseled Francisco Diaz. Have you counseled him during the entire period of time he has been stationed at this clinic?

A Yes.

Q How often have you counseled him?

A Well, I have been counselor there two and a half years. I would say after I got to know him, about once every two weeks, about once every three weeks. He would be a patient that we would consider required a minimal amount of counseling.

Q Could you explain that, please? You described on average you counsel patients once or twice a week. Why was he seen once every other week?

A For one thing, he has been there since '67. He has a very good work record. There has never been any behaviorial problem or abusive language problem in the clinic. His problems seem to be minimal.

Q Does he attend regularly?

A Yes.

Q Does he ever miss his medication?

A Not often, no.

Q What happens when he does miss his medication? Does he call in?

A He always calls when he is going to be late or if he feels he can't make it into the clinic.

Q Are you aware of why he has been late or hasn't made it to the clinic?

A Yes.

Q What reasons are those?

A He secured a job in Yonkers and working hours were such that he could not make it into the clinic during the hours.

Q Miss Brown, during your association with Francisco Diaz, have you witnessed him on occasions when you were not counseling him?

A Oh, yes.

Q You have seen him around the clinic?

A Sure.

Q You are referring to former counseling sessions?

A Yes.

Q On these occasions, as well as during the formal counseling sessions, have you ever observed anything in Mr. Diaz affect, any odor on his affect or any other factors that would cause you to suspect that he is a user of alcohol or was intoxicated during his clinic visits?

A No.

Q Have you ever asked him about his drinking?

A Yes, I have.

Q Why do you ask him?

A Well, he was there before I was and I read the previous counselor's notes and it made me aware that they must have thought there was a problem. I never saw that.

MR. BALBER: Thank you.

CROSS EXAMINATION

BY MR. DUNN:

Q Miss Brown, what problem had been noted by the former counselor with respect to Mr. Diaz?

A There was a period when his eyes appeared red, so that she thought there might be a drinking problem.

Q Was Mr. Diaz free of illicit drug use during his period of treatment?

A Yes.

Q At all times?

A There were some positive in the urine. I asked him about it.

Q Positive for what?

A I think they came up with amphetamine.

Q When did this come up with respect to the amphetamine?

A I would say about eight months after he came in I saw that.

Q Can you pinpoint that as far as the dates?

THE COURT: Don't you have the dates that it happened?

THE WITNESS: I asked him about it. He admitted to me one cocaine abuse, and then when he showed up again he said that he was on a prescription from a doctor for back pain, pain killers, some pills for his back, and I asked him to bring them in, which he did, and he showed them to the nurses, and there was something in them that would have shown up as amphetamine.

Q Did you say that cocaine was taken because of a back pain?

A No.

Q For what purpose?

A I said that when it kept showing up he said that it could be from these pills that he was taking for his backache, and I asked him to bring them in, which he did. We showed them to the nurse and she looked them up in the medical book and found the could show up as an amphetamine, and I believe he discontinued taking them and the positive urine stopped.

Q Did you make a notation to that effect on the record?

A I hope so.

Q I'm asking you whether you did.

A I don't remember.

THE COURT: Do you have it?

MR. DUNN: We find no such notation in the record. That's why I asked the witness.

THE COURT: If you looked at it and can't find anything, do you remember the date?

THE WITNESS: No, as I say, it was maybe six, eight months after I came there.

THE COURT: When did you come?

THE WITNESS: October of '72.

THE COURT: Next question.

Q Now, two months after you came I find a notation on the record cocaine showed up on his urinalysis, referring to Mr. Diaz.

THE COURT: What was the date?

MR. DUNN: December '72, your Honor.

THE COURT: All right.

Q "I became quite concerned because Francisco is such a good patient and no drug abuse has been evidenced since he came on the program. He admitted that he did, in fact, use it one time at a party when someone offered it to him. He said it happened just that once and this was the first time in three years. He said it would not happen

again and thus far it has not."

And that notation is signed Brenda Brown. Do you recall that?

A Yes.

Q You are telling us, then, that in December of '72 he used cocaine and then amphetamine showed up some eight months after that?

A No. When I said it was six to eight months, it must have been that period of time. I told you I didn't remember the exact date. That is when it showed up, that period of time.

MR. DUNN: I would like to defer further examination of this witness. I want the records of Beth Israel. What we have are Xerox copies, some of which are totally impossible to read. They are illegible.

THE COURT: Complete your cross examination. You had a lot of opportunity to get records before now and we had these witnesses come in, and it is 6:00 at night. You do the best you can right now. If there is an absolutely urgent reason to recall a witness, we may consider it.

MR. DUNN: Very good, your Honor.

May I have this marked?

(Defendant's Exhibit FFF marked for identification.)

Q Miss Brown, I show you Defendant's Exhibit FFF for identification and ask you if you recognize that as a document maintained at the Beth Israel methadone program referring to Francisco Diaz?

A Yes.

MR. DUNN: I offer Defendant's Exhibit FFF, your Honor.

MR. BALBER: No objection, except to note that the document is undated.

MR. DUNN: The document bears the date November 9th.

THE COURT: Received.

(Defendant's Exhibit FFF received in evidence.)

Q Can you tell us, Miss Brown, what this form is?

A It is an obsolete form. We don't use it any more.

Q What was it used for at the time?

A It was used as a progress note that was made on a patient each time we saw him.

Q Do you know when that was prepared?

A This particular one?

Q Yes, m'am.

A No, I don't.

Q Is there a signature on the form?

A Yes.

Q Do you recognize the signature?

A No, I don't.

Q During what period of time was that form used on the program?

A When I first came there they used it maybe for about six months or so that I was there.

Q You came there in October?

A Of '72.

Q This could have been November '72. It has November 9th, but not the year.

A Yes, it could have been. I don't know.

Q Will you read the information, please? This appears in item C.

A Abuse of drugs and there is a check Observed by Staff.

Q Will you read for us, please, what appears after the printed words Progress Notes?

A Drinking, and the word "Tremors."

THE COURT: What?

THE WITNESS: Tremors.

MR. BALBER: I would like the record to reflect that the word drinking is followed by a question mark.

THE COURT: All right.

Q What is the significance of tremors being noted on the progress note, if any?

A Whoever wrote it up must have observed that he shook.

THE COURT: This was what date?

THE WITNESS: It says 11/9.

THE COURT: Of what year?

THE WITNESS: It doesn't have a year.

MR. DUNN: I have no further questions, your Honor.

THE COURT: Anything else of this witness?

MR. BALBER: No.

THE COURT: Miss Brown, you are excused.

* * *

MARYBELLE ADELSON PERLMAN,

a witness called on behalf of the plaintiff, being

first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. BALBER:

Q Can you describe your professional education and training?

A I graduated from college with a Bachelor of Arts degree and had 30 graduate credits in psychology. I returned to graduate school in 1964 and got a Masters in '65 at NYU.

Q Have you served as a member of the professional staff of the Veterans Administration methadone maintenance program?

A Yes.

Q In what capacity?

A Vocational rehabilitation specialist.

Q During what period of time were you employed with the VA program?

A Since its inception in November of 1970.

Q Were you stationed in a particular methadone clinic?

A I was stationed both in the in-patient facility at Manhattan VA Hospital and the out-patient clinic.

Q What was the purpose of that in-patient facility?

A Initially it was felt that methadone patients required a six week in-patient treatment, and after they were discharged, out-patient clinic, and that was the purpose of the hospital facility.

Q Has that facility now been abolished?

A Yes.

THE COURT: I am not clear. Are you still with the VA?

THE WITNESS: Yes.

Q In what capacity do you now serve with the VA?

A I work with the alcohol rehabilitation program.

THE COURT: When did you stop with the methadone?

THE WITNESS: Approximately October of 1974.

Q Just to refresh our recollection, when did you start?

A November of 1970.

Q Where was the out-patient clinic located in which you served?

A At 255 Seventh Avenue, on the ninth floor, in Manhattan.

Q How many VA out-patient methadone maintenance clinics are located in Manhattan?

A Just one, to my knowledge. There are two clinics in that one clinic, but the only VA methadone clinic in Manhattan is that one, to my knowledge.

Q It is one physical facility?

A Yes.

Q But there are two separate clinics?

A Yes. Both located on the same floor.

Q Separate entrances?

A Yes.

Q And different patient populations?

A Yes.

Q How many patients are enrolled in each clinic?

A Between 150 and 160 in each clinic. Which is why they are divided.

THE COURT: Did you say they are both methadone clinics?

THE WITNESS: Yes. But 350-odd patients is too much for one clinic. It's one program but it was divided

into two clinics.

THE COURT: About 150 each?

THE WITNESS: About 155 each, approximately. I don't know the exact number.

Q Just so we understand each other, these figures are only as of this past fall when you left the program?

A Yes.

Q Can you describe what staff members work at each of those clinics?

A There is one medical doctor that covers both clinics. There is one psychologist who covers both clinics, and there is one occupational therapist who covers both clinics. There is a vocational rehabilitation person in each of the clinics. There is a nursing staff, which includes at least two nurses in each clinic, and there are, as I remember, four counselors in each clinic.

There is also a hospital backup for people requiring more acute care.

Q Before we get to the hospital backup, are there any additional people employed in the clinic? Is there any clerical staff?

A Yes. There is a secretary and there is a security guard.

THE COURT: In each one?

THE WITNESS: There is a secretary in each clinic and I believe there is one security guard for both, since they are adjacent to each other, and he is readily available to both.

Q Did you say there was also a social worker?

A Yes. There was a social worker when I was working there, there was a social worker in each clinic, and I believe one is left, but they are about to replace him.

Q What kind of activity did that social worker engage in?

A It was a combination of things. Welfare problems, psychiatric social work problems, group therapy, individual therapy.

Q Any family therapy ever involved with the counselor?

A Family therapy.

Q What activities did the psychologist engage in?

A Group therapy, individual therapy, and psychological testing as needed.

Q What was the function of the nurses?

A The nurses' function, they gave medication as prescribed by the physician; they reported to the rest of the staff how the patients looked, how they seemed to feel; they were a means of conveying information, since they saw

the patients more frequently than the other staff did. But their primary purpose was to give medication and to record, keep records.

Q Did they refer patients with particular problems?

A Yes.

Q What did you do specifically as a vocational rehabilitation counselor?

A Well, I have interviewed every single patient who came in to this program except for approximately 50 or 60 ambulatory patients who did not come through the hospital. So I have interviewed thoroughly in terms of my profession, vocational history, educational history, and so forth, approximately 500 patients.

I then evaluated them together with the patient and the other staff, what services were needed and referred them to such services, and I worked with them on an on-going basis.

Q What kinds of specific services did you refer them to?

A Training, high school equivalency programs, shelter workshops both within the VA and outside, job placement, I did--

Q Skill training?

A Skilled training and unskilled training. What-

ever was appropriate to their skills and interests.

Q Were any of these referral services through the general Veterans Administration apparatus. Were they made available through the VA as opposed to outside people?

A You mean jobs or--

Q No, the vocational training.

A Oh, because veterans do have GI benefits and other special benefits that non-veterans don't have, there was more available to them through the Veterans Administration.

Q Were there any other backup services other than those provided directly at the clinic or made available to your patients?

A Well, we had the VA Hospital that provided back-up medical and psychiatric services to out-patients, as well as the out-patient clinic. There were other medical services than ours located within the out-patient clinic.

Q How often did your clinic utilize these services?

A Well, as often as was necessary. They were available to us.

Q Was it an uncommon occurrence?

A It was a common occurrance to use all the medical services in both areas.

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Q Miss Perlman, previously in this case there was testimony by a witness about servations that he had made about Veterans Administration methadone programs, and I would like to read to you briefly what he said. It's on page 454 of the transcript. There was a question from the Court about alcohol abuse.

"Does alcohol turn up?

"THE WITNESS: Not alcohol necessarily, although that could turn up. The problem there," he talking now about methadone programs, "is the control one where the patients may attend clinic while intoxicated and I have seen patients drinking on the premises of the clinic.

"THE COURT: What clinic? The VA clinic?

"THE WITNESS: Yes. Particularly the one at Ft. Hamilton, the Brooklyn VA.

"THE COURT: Why would they drink at the clinic?

"THE WITNESS: "--

THE COURT: There is no reason to read all this. You can ask a very brief question. Just tell your problem and--

Q Okay. Miss Perlman, to what extent during your association with the VA program did you witness social congregation on the premises of the VA clinic where you worked?

THE COURT: We have had the--here's the point,

there's been evidence about some kind of difficult behavior, passing drugs, and drinking outside in and around these clinics. What have you observed in the clinics which you have seen? Tell us about that, would you?

THE WITNESS: Yes. In the clinic itself I myself have never seen drugs passed or alcohol being held in hands. There have been problems outside the clinic which we have tried to control by contacting both Federal authorities and the New York City authorities. They are a very small group of patients and because they are problem patients they require an exaggerated amount of attention, which seems to permeate or put its toll upon all programs.

However--

THE COURT: What do you observe? You say you have observed outside your clinic.

THE WITNESS: On the street.

THE COURT: Does that refer to a small group? You mentioned a small group.

THE WITNESS: Yes,a small group.

THE COURT: Problem patients?

THE WITNESS: Yes.

THE COURT: About how many?

THE WITNESS: Anywhere from a half a dozen to a dozen, that I have seen.

THE COURT: What do they do?

THE WITNESS: I think they are mostly involved with alcohol, the ones I have seen.

THE COURT: What have you tried to do about that?

THE WITNESS: We have tried everything within our power. We have tried to both voluntary and mandatory group programs specifically directed to alcohol abuse. We have tried referring them to physicians. We make them come in for their medication every single day. We have tried referring them to in-patient psychiatric services or to Halfway Houses that deal specifically with the problem, and finally with some patients we feel that we have been unable to do anything. But this is a relatively small group of patients.

THE COURT: Anything else?

Q Mrs. Perlman, was Carl Beazer one of the persons whom you have dealt with professionally?

A Yes.

Q When did you first meet Carl Beazer?

A When he entered the program, the first week he entered.

Q About when was that?

A I have 500 people. I have to refresh my

memory for the exact date.

(Pause.)

A He entered in May of '71.

Q Where did you first meet him?

A In the hospital ward, the methadone ward at that time.

Q Will you describe what happened at that first meeting?

A Yes. I interviewed him as I did all the patients. His work history, and so forth, his education and his general background and skills. His motivation, and so forth.

Q Did you make a professional assessment of Mr. Beazer at that initial meeting?

A Yes. His intention was to return to his position in the Transit Authority, and my feeling was that a man who had worked for 11 years and had received the promotions he had was qualified and motivated to do so. He was able to sustain quite a long work history.

Q After your initial contact with Mr. Beazer did you continue to have dealings with him while he was an inpatient?

A Yes.

Q How frequently did you see him?

A Well, I saw him every day. In terms of more

extensive counseling, it varied. We saw the patients in groups at least once a week. I would say on the average of once, twice a week while he was in the hospital.

Q At the time Mr. Beazer was discharged from the hospital, did you at that point make an evaluation of his job rating?

A I felt the same way, that he was able to return to work.

Q What did you base that assessment on, what particular factors?

A He did very well in the hospital. He responded very well to both the medical treatment and the other therapies, and he seemed motivated to return to work. He was a good patient.

Q What were the inditia of that motivation?

A He participated in all of the activities of the program in the hospital, and he was responsive to the staff's suggestions in terms of his therapy.

Q When you said he was motivated, how did you assess that?

A Well, we have various programs. We have educational therapy and occupation therapy, and I worked very closely with both of those therapists to see how patients function, and it's a very--occupational therapy especially

is a very good way to see how people function in what seemingly are non-work tasks, but really are work tasks. And he was responsive to all of the areas that were provided by our program.

Q After Mr. Beazer was discharged as an in-patient did you continue to counsel him?

A Yes.

Q And that counseling occurred at the out-patient facility?

A Yes.

Q How frequently did you counsel him?

A At least once a week. Sometimes two or three times a week.

Q Was this in addition to the counseling that he was receiving from his other counselor?

A Yes.

Q What did you observe about Mr. Beazer's after-effect in the clinic during this period?

A He seemed perfectly fine.

Q Did he comply with clinic rules?

A Yes.

Q Did he attend regularly?

A Yes.

Q Did he appear motivated?

A Yes. Very.

Q Why do you say very motivated?

A When he came into the program, he was very discouraged and depressed. He needed reassurance about his ability to deal with his problem, and I think after a discharge from the hospital he felt a great deal of support in addition to the medical treatment he was receiving, and his attitude progressed.

Q Mrs. Perlman, were there procedures by which you would have been notified if Mr. Beazer was abusing drugs or alcohol while he was in the program?

A Yes.

Q How would you have found out?

A Both from the nurse and his counselor.

Q During the time that you counseled Mr. Beazer did you ever have reason to believe that he was either abusing drugs or alcohol?

A No.

Q Mrs. Perlman, at the time Mr. Beazer was fired from the Transit Authority, did he ever indicate to you or other staff members that he was contemplating returning to drugs?

A No.

MR. BALBER: Your Honor, Mr. Beazer was detoxed

from methadone. It is stipulated as to that.

Q After Mr. Beazer was detoxified from methadone did he continue to attend the VA program?

A He continued to attend what we call the after-care program.

Q What does that program consist of?

A It consists mostly of a group counseling session or some contact with the aftercare counselor and the submission of urine samples.

Q Did you continue to counsel him during this period?

A Yes.

Q What was your assessment of his progress as a detoxified patient?

A He continued to make the same good progress that he had made previous to.

Q During this time period are there procedures by which you would have been notified if he was abusing drugs or alcohol?

A Yes.

Q Was such abuse ever brought to your attention?

A No.

Q And Mr. Beazer did give urine specimens?

A Yes.

Q Were these given voluntarily?

A Yes.

Q Do you continue to counsel Mr. Beazer today, Mrs. Perlman?

A Yes.

Q How frequently do you talk to him?

A At least once a month, and sometimes more frequently than that.

Q Does he have access to you at home?

A Yes.

THE COURT: I'm sorry. You probably said this and I missed it. Does he still give any urine specimens? Is that part of your aftercare program?

THE WITNESS: That is part of the aftercare program.

THE COURT: About how often?

THE WITNESS: I'm not sure. I really can't answer that exactly, your Honor. It's at least once every two weeks. It may be more frequent than that. And if the patient has a problem I know it's more frequent than that.

THE COURT: How often would he come into the clinic?

THE WITNESS: Well, initially I saw him once a week.

Q Mrs. Perlman, do you know if Mr. Beazer continues to receive services from other staff members?

A I don't believe so. I think he does see the psychiatrist who was attached to our program at one time.

Q Do you know how often he sees the psychiatrist?

A I think it's once a week, but I'm not sure of that.

Q Mrs. Perlman, have you ever had the occasion to visit the offices of the New York City Transit Authority?

A Yes.

Q When did this visit occur?

A It occurred shortly after I went to work for the VA when I was doing a lot of job development work, and I made an appointment to visit their department of personnel. This was before Mr. Beazer entered our program, by the way.

I spoke to someone in personnel who referred me to the physician in charge at the Transit Authority, and I then spoke to him and another man who was present; I don't remember his name.

Q Do you recall the name of the physician in charge?

A I believe it was Dr. Lanzetta.

Q Mrs. Perlman, did you offer at this time to provide any services to the Transit Authority?

A Yes. We told Dr. Lanzetta that we were interested in referring qualified applicants for positions with the Transit Authority and that we would screen them very carefully and work cooperatively with the medical and personnel departments on an ongoing basis before and after employment, to secure employment for such people.

Q Did you offer to bring problems to the attention of the Transit Authority with persons you have referred before the Transit Authority itself was aware of those problems?

A Yes. We always do that with employers.

Q That also includes problems with drug abuse?

A Yes.

Q Mrs. Perlman, can you as specifically as possible state in what occupations persons in the VA program with whom you have been associated have been employed?

A In practically every occupation that--I just would like to refer to this very quickly.

We have had 11 people who work for the Telephone Company as mechanics. We have had about 30 people who work for the Post Office in various capacities. We had four people who work for the Transit Authority before they came into our program. Two as towermen and two as porters--

THE COURT: Are you including people who worked before they got into the methadone program?

THE WITNESS: This is when they were addicted to other drugs, and some of them continued their employment.

THE COURT: That isn't going to help us very much.

Q Do these persons now work for the Transit Authority while they are on methadone?

A No.

Q They have been discharged?

A If you are talking about the kind of skills patients brought with them to our program, this is what I am referring to.

Q What we are trying to get at is, what jobs people whom you know and have counseled have held while maintained on methadone.

A It's the same variety of jobs. Some people have got them, even though the employer knew they were on methadone, but unfortunately most of them have gotten it just based on their skills, and these are clerical jobs, mechanics' jobs, security guard jobs, truck drivers, the Post Office, factory labor, mechanics.

Q These people are now on methadone?

A Yes.

Q You don't have to name who the employees are; are there any persons whom you have counseled who work for

the Transit Authority while they are on methadone?

A I don't believe so. Not in our program, but I know others.

Q Mrs. Perlman, do you know how well these methadone maintained employees you are talking about, I'm not talking about the Transit Authority employees, but the others you have referred to, how well they have been doing on the job?

A They do as well as any other person would do on or off methadone or any other drug, given their skills and aptitudes.

Q Do you know for what periods of time they have been employed?

A It varies. I have kept a record of it, but I have to sort of look it up. Some of them are employed by months and they go on to better employment or other employment. Others are employed for over years. It varies individually. I have it written up but I don't have it.

Q Do you know the names of the specific companies they work with? You mentioned New York Tel. Do you know other companies?

A Benton & Bowles, General Electric, the Veterans Administration, various small companies. Bankers Trust--

Q In what capacity do they work at Bankers Trust?

A Clerical. There are a lot of security guards.

Q For whom do they work as security guards?

A Security guard agencies. I can't recall the names offhand.

Q Like Burns, would that be one?

A I don't recall Burns as being one of the employers. They are lesser known agencies. United Parcel Service.

Q What do they do for United Parcel Service, do they drive trucks?

A Some of them drive trucks, some of them work as truck loaders.

Q Can you think of any other employers?

A I can't offhand. Department stores, well known department stores.

Q What do they do at department stores?

A Stock work, sales work.

Q Do any of them operate machinery in stockrooms, for example?

A Well, you mean like ticketing machines, that sort of thing. That is an entry level occupation. They certainly would be able to do so.

THE COURT: What proportion of your patients are employed?

THE WITNESS: Well, I left there in October of

last year and in the clinic in which I worked there were about 156 people. I would say about maybe 60 to 70 per cent were either employed or in school or in the curative workshop, which I would consider a kind of employment.

THE COURT: The curative workshop?

THE WITNESS: It is a pre-vocational evaluation, a kind of a sheltered workshop that is within the facility of the Veterans Administration on Seventh Avenue, to which I referred patients to help them proceed toward employment or other training.

Q If you were to break out the curative workshop, what percentage were employed?

A I would say between 40 and 50 per cent.

Q Does that percentage change if you were to take the patient population that has been in treatment for say a year?

A It changes all the time. It's very hard to give an honest exact figure. Just as the Department of Labor changes their statistics every month, so does the methadone program, and it's very hard to give an exact figure.

MR. BALBER: Thank you.

THE COURT: Any cross?

CROSS EXAMINATION

BY MR. DUNN:

Q Do you know how many methadone maintenance clinics the VA operates in the Metropolitan area at the time?

A I am aware of the one in East Orange, New Jersey, and the Brooklyn VA, and the Bronx VA.

Q What about the one in Manhattan?

A And the Manhattan VA.

Q Two in Manhattan, rather?

A There are two clinics but it's under one administration.

Q Why did you leave the position in October, 1974 with the program?

A I was working part time for the alcohol program, the alcohol program started a little over a year ago, and they asked me to work part time with the alcohol program and part time with the methadone program. In October I was asked to work full time with the alcohol program because it was having two jobs with one person and it became very difficult.

Q How many times have you visited the Veterans Administration methadone treatment program in East Orange, New Jersey?

A Once.

Q And the one in Brooklyn?

A I have never been to that one.

Q The one at Ft. Hamilton?

A No.

Q You have never observed whether the conditions that were testified to by another witness--

THE COURT: She never was there; she didn't observe. It's too late for that.

MR. DUNN: I withdraw the question, your Honor.

Q You ventured an opinion with respect to the employability of Mr. Beazer. At one point in his treatment when he was being maintained on methadone, would you consider a person who was taking heroin to be employable?

A There are such people, yes, who are employable and who are employed.

Q How would you determine whether or not a person is employable while they are taking heroin?

THE COURT: We are really not--nobody is seeking to assert the right of heroin users to be employed. I don't mean it is without point, but can we avoid it as much as possible?

MR. DUNN: I think we can, your Honor.

Q How many times have you seen Mr. Beazer since October, 1974, Mrs. Perlman?

A I would say four or five times, but I have spoken to him on the telephone much more frequently than that.

Q What were the occasions of your seeing him these four or five times?

A At the clinic.

Q You left the clinic in October, 1974?

A Yes, but I still continue. I visit the out-patient clinic once a week to follow up on alcohol patients who I have referred there, and I meet methadone patients while I am there.

Q Did I understand you to say Mr. Beazer has access to your home?

A Yes.

Q What was meant by that?

A Because of the special nature of his case. He is the only patient who does, and because of the very special services that were needed in his case.

Q Would you describe the special services and the special need that provoked the services?

A Yes. This happened after he was discharged from the Transit Authority and our VA program tried to get him the best possible help to resume his position there, and so a great deal of effort and attention outside of the normal working day was required to do so. And that is why he had access to my home and also this psychiatrist's home phone.

Q Which psychiatrist?

A The psychiatrist who was the head of our program at that time.

Q How many times did Mr. Beazer avail himself of the access he had to your home?

A He availed himself when necessary. He never abused the--he never called me an extraordinary number of times. He called me when it was necessary, if something had come up that he felt was important to his case or if he needed some counseling in a particular area. Sometimes this was once a week, and sometimes it was two or three times a week.

Q Did he call you on the telephone?

A Yes.

Q Would he visit you at home?

A No.

Q By access to your home, you mean that he had your telephone number and was able to call you by telephoning you?

A Yes.

Q But he never had occasion to visit you at home?

A No.

Q Does the Veterans Administration to your knowledge, Miss Perlman, make known the affects concerning Mr. Beazer's treatment with methadone at the time that he returned to the Transit Authority, that is, in the period of about June, 1971?

A Can you restate that?

Q Yes. Mr. Beazer was hospitalized. Mr. Beazer was being treated with methadone. There came a time when Mr. Beazer returned to the Transit Authority and had to explain the reason for his medical absence, and I ask you, did the Veterans Administration at that time make known to the Transit Authority the reason for Mr. Beazer's hospitalization?

A It is the policy of the Veterans Administration,

and this is under penalty of punishment, not to reveal anything about patients to agencies outside of the Veterans Administration. So we would not have to our knowledge, to my knowledge, revealed any information about any patient to any other agency.

Q At the patient's request, would you do that?

A It requires very special consideration. I think it was a law that was passed by Congress, as a matter of fact, to respect the patient's privacy.

Q You mean the patients that are being treated at the Veterans Administration Hospital for any purpose?

A For any purpose.

Q Or is this limited to methadone maintained patients?

A No, for any purpose, and when information does get out, it is very carefully handled and under special circumstances.

Q Can you describe how it is handled?

A I can't describe how it is handled because I am not involved with the release of information.

Q What information would the Veterans Administration give with respect to the one of its methadone maintained patients if that patient requested a prospective employer be given the information?

A We would consult our lawyer as to just how that could be handled.

MR. DUNN: I have nothing further, your Honor.

REDIRECT EXAMINATION

BY MR. BALBER:

Q Have you had occasions with employers where you did give them information about prospective employees?

A Within the guidelines, and we do inform them of the patient's progress and if there are problems once there is open knowledge of it on both sides.

MR. BALBER: Thank you.

(Witness excused.)

THE COURT: We will reconvene at 2:00 on Friday.

(Whereupon, an adjournment was taken to February 7, 1975, at 2:00 p.m.)

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mbs 1063

CARL A. BEAZER, et al.,

vs. 72 Civ. 5307

NEW YORK CITY TRANSIT AUTHORITY.

Before:

HON. THOMAS P. GRIESA,

Distict Judge.

New York, February 7, 1975.

J O Y C E L O W I N S O N , called as a witness in behalf of the plaintiffs, being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. BALBER:

Q Dr. Lowinson, is this a copy of your curriculum vitae?

A Yes, it is.

Q Does it accurately reflect your professional qualifications and experience?

A Yes, it does.

MR. BALBER: If there is no objection, your Honor, I would like this marked as Plaintiff's Exhibit 57 and receive it in evidence.

MR. DUNN: No objection.

(Plaintiffs' Exhibit 57 was received in evidence.)

Q Dr. Lowinson, your curriculum vitae states that between 1965 and 1967 you were unit director of the Beth Israel methadone maintenance treatment program.

Can you describe for the Court exactly what your professional responsibiliities were in this position?

A Well, in addition to the administration of the unit, I was responsible for selecting the patients for

admission to the program.

THE COURT: I was getting something else. Let me have that question again.

Q Dr. Lowinson, your curriculum vitae states that between 1965 and 1967 you were a unit director of the Beth Israel methadone maintenance treatment program. Can you describe what your professional responsibilities were in this position?

A Well, beginning in '65, I was responsible for the administration of the original unit.

Q Is this the first methadone unit?

A This was the first methadone unit after the research had been done at the Rockefeller University when the transition was made to a pilot program.

At that time I was responsible for selecting the patients along with Dr. Marie Nyswander. We screened patients carefully at that time in terms of the length of their addiction. We tried to take the patients who had been longest -- I shouldn't say the longest but who had the most complex background, people who had been in treatment programs repeatedly and had relapsed to the use of drugs.

We took patients who were over the age of 21 because at that time we felt this was research and we did not want to take a younger patient We screened out

patients over the age of 40 because there is a myth around that heroin addicts grow out of their addiction, they mature out of their addiction.

We eliminated people with medical problems and with psychiatric problems because we were testing the effectiveness of methadone in the treatment of narcotics addiction, and we wanted to keep our sample pure. We did not want to be dealing with multiple problems.

But in short, we tried -- we selected the patients who we felt were the poorest risks.

Q We won't get into your results in detail because Dr. Dole has already testified about a lot of them.

How successful were you in eliminating drug abuse after, say, the first six months of treatment among these people?

A It was remarkably successful. The retention rate was, I think, 85 per cent in the first year. I am not sure of the figure at six months but was 85 per cent in the first year, and close to 80 per cent of those patients were employed at the end of the year in treatment.

Q These patients were all maintained on high dosages of methadone, between 80 and 120 milligrams?

A Yes.

Q Doctor, your curriculum vitae also states that

you have been associated with Van Etten Hospital. Can you describe what work you have done there?

A Yes. In 1966 when the problem with tuberculosis was generally pretty much resolved because of the innovations in antibiotic therapy, there still persisted a problem of the tubercular addict. 95 per cent of the tubercular addicts who were admitted to Van Etten Hospital left the hospital before their sputum was negative, which means that they were still contagious and could infect the rest of the community.

Q What did you do at Van Etten? Did you establish a methadone program there?

A Well, we set up a small research program there and heroin addicts who came into the hospital, as soon as they were identified and were seen by a counselor, and a determination was made as to whether or not the patient could be detoxified with methadone or maintained on low doses of methadone, 95 per cent of those patients, as I said, remained in treatment, remained in the hospital until they finished their in-hospital treatment. They went on to ambulatory care.

Of that group of patients, the majority of them stayed in ambulatory -- I am not familiar with the most recent follow-up, but I think that the follow-up statistics

are close to those at Beth Israel and Bronx State.

Q Doctor, your curriculum vitae also states that since 1968 you have been chief of the drug abuse service at Bronx State Hospital, and that since 1969 you have been director of the methadone maintenance treatment program at Albert Einstein College of Medicine.

A Correct.

Q Can you describe what your responsibilities are in these positions?

A As chief of the drug abuse service, we are responsible for all the drug problems that come into the hospital, whether on our service or on a psychiatric service.

We evaluate patients, whether they are addicted to narcotics or sedative drugs or cocaine or amphetamine, and where possible, we treat the patients on the ward where they are admitted.

Patients who are heroin addicts, with the help of methadone become accessible to psychiatric care. If they are not given methadone, if they are not put on methadone maintenance, the patients usually leave the hospital. They may be in and out of the hospital, but they have frequent psychotic episodes as a result of the inability to give them the constant care they need. With the help of methadone maintenance, as I say, they are

accessible to psychotherapy, just a patient with tuberculosis is accessible to medical care.

MR. DUNN: May I request that the witness be invited to keep her voice up? It is very soft and doesn't reach the counsel table.

THE COURT: A little louder and a little slower.

THE WITNESS: I apologize. I have a cough which is going to present a problem.

THE COURT: I would like the last answer read, if you don't mind, Mr. Reporter.

(Last answer read.)

BY MR. BALBER:

Q Now, Doctor, correct me if I am wrong.

What you just described as inpatients is people who were initially inpatient in the hospital?

A Yes,

Q Do all of your patients enter through the inpatient route or do some come in on an ambulatory basis?

A I was only describing the general services of the hospital. For the methadone maintenance program, patients are seen at an intake office where they are evaluated by a social worker, by a counselor who is an ex-addict and who has had lengthy experience on the program, and also by a physician.

If he is found to be addicted only to heroin, if there is not an accompanying addiction to barbiturates or alcohol, we then assign the patient to a clinic and he is stabilized on an ambulatory basis.

Q Throughout this lawsuit people have been referring to the Bronx State methadone program. When you talk about the ambulatory program are you talking about the Bronx State methadone program?

A It is what is referred to as the Bronx State program. It is actually the Albert Einstein College of Medicine, Bronx Psychiatry Center.

BY THE COURT:

Q Are you saying that y... program only admits the single drug addict, the heroi... ddict, and you do not admit anybody if you feel that there is a problem, a multiple drug or alcohol use problem?

A I'm sorry if I didn't make that clear.

Those who have single addiction problems are admitted for ambulatory stabilization whereas patients who are victimized by multiple addiction problems, if they are addicted to barbiturates or to alcohol, we admit them to our inpatient unit where they are detoxified from the secondary drug abuse.

If a patient were to stop taking barbiturates or alcohol suddenly, he might suffer convulsions or other symptoms of withdrawal.

BY MR. BALBER:

Q Once this patient is detoxified, you accept him on an ambulatory basis?

A Once he has been detoxified, he is stabilized in the hospital at the same time.

Q But not detoxified from heroin; it's just the secondary drug?

A Right.

BY THE COURT:

Q How do you toxify somebody from other drugs?

A Well, for people who are addicted to barbiturates, we use sodium ammitol and gradually diminish the doses. And for people who are addicted to alcohol, we use librium.

Q In other words, on those other drugs there are methods of detoxification?

A Yes.

Q How long does that take?

A Well, the actual detoxification takes a week, but we keep patients in the hospital for a period of three weeks to avert the possibility of any complications that might occur after their last dose or the withdrawl medication.

BY MR. BALBER:

Q Dr. Lowinson, a psychologist by the name of James C. Higgins has previously given some testimony in this case about the size of the Bronx State program and about how you conduct your operations.

If I could just read you very briefly a few words that he said, beginning at page 457 of the transcript, he stated -- the judge in this case asked:

"How many do they have at Bronx State?" -- referring to numbers of patients.

The witness replied:

"Bronx State is a very large program. I would think about 3000 or more.

"Q At one facility?

"A Yes. Well, they have a number of clinic facilities in the Bronx. I would say at the Bronx State Hospital itself there may be about 2000. I think they had --

"Q Does that mean coming in every day?

"A Yes.

"Q 2000 to one facility?

"A Yes."

Now, Dr. Lowinson, do you have 3000 or more persons enrolled In your program?

A No, we do not.

Q What is the sensus in your program?

A I think it is 2167 at present.

Q And are all of those patients --

A 2136. I'm sorry.

Q 2136?

A Yes.

Q And are all of those patients being maintained by methadone?

A No. About close to 250 are drug free. They

have been detoxified from methadone.

Q They are in after care programs of some sort?

A Yes. 267 are not on methadone but are currently being followed.

Q Now, do you have 2000 persons in attendance at the Bronx State Hospital itself?

A No. We have two clinics at the Bronx State Hospital, and at one clinic we have 296 patients and at the other we have 348.

Q So you have a total of about 600 people at the hospital itself?

A That's right.

Q And do all those people come in every day?

A No.

Q How often do they come in?

A At one clinic we have an average of 196 visits a day, and at the other clinic we have 187. It is a range of 20 to 287 a day.

THE COURT: I didn't get that.

THE WITNESS: It's a range of 20 to 287 a day. Saturday is the day that we have --

THE COURT: Oh, I see. So your average per day included those highs and lows, of course.

THE WITNESS: Right.

THE COURT: And you said at one of the clinics there were 196 per day?

THE WITNESS: 196.

THE COURT: And the next clinic?

THE WITNESS: 187.

THE COURT: And it ranges from where to where?

THE WITNESS: 20 to 287.

THE COURT: And that is at the hospital itself, right?

THE WITNESS: That's right. We have two clinics located at the hospital, on the hospital grounds.

THE COURT: Okay. You are going to ask about the others now?

MR. BALBER: Yes, your Honor.

BY MR. BALBER:

Q Dr. Lowinson, Dr. Higgins also stated about the hospital facility -- he said on page 457 of the transcript --

"The Bronx State has been required to set up its facility in trailers adjoining the hospital so as to partially contain some of the management problem it experienced in running such a large case load as they had."

Now, Dr. Lowinson, does your program utilize trailers at the hospital?

A Yes, we do.

MR. DUNN: Your Honor, I notice that there are additional witnesses in the courtroom now. I hadn't noticed them until just now. I request that they be excluded from the courtroom.

MR. BALBER: There is just one additional witness in the courtroom, your Honor.

THE COURT: Well, I think we are carrying this a little too far.

MS. DuBOIS: One is Just to fill the ART statistics and there is no one who --

MR. DUNN: But they are associated with another program and I think that --

THE COURT: Well, we are carrying this to an absolutely ridiculous degree. I don't see any problem in having them sit here.

Okay, go ahead.

BY MR. BALBER:

Q Now, can you describe what those trailers are like physicially and how you came to use them?

A Well, I felt that it was a rather interesting innovation how we came to use them.

In 1968 we were awarded $2-1/2 million by Governor Rockefeller to set up clinics that would take care

of 2500 people on our waiting li[illegible]

As you probably know, it takes a long time to convert space that you obtain: store fronts, which is where clinics are usually set up. It takes a period of at least six months to convert that space into something usable.

To speed up the process, I decided that I would put trailers up. This was something that could be accomplished in a period of four weeks.

We planned on using one of the trailers as a rapid induction clinic, a place where people could be built up.

It didn't mean that we were going to build them up rapidly but we were going to get them into treatment rapidly.

By having set up these two trailers, we were able to advance the date of treatment for some 600 patients by about six months.

Q Dr. Lowinson, can you describe the physical appearance of the trailers?

A They are beautiful. They are L-shaped trailers. The basic trailer itself is 60 feet by 12.

And then we have an extension that is the same width, about 45 feet in length.

They have been decorated by Fordham College students in very atrractive styling, and they have been landscaped by the staff.

They are considered one of the more attractive features up at the hospital.

They are designed or laid out in such a way that we have separate offices for all of the counselors, for the physicians.

We have a nursing station which accommodates three nurses. We usually have three nurses in a station at a time, and a fourth nurse is free to engage in other activities.

The supervisor has her or his own office. In general, it is a rather spacious and attractive facility.

Q Have your patient been borrowed from the general hospital facilities?

A In no way.

Q Can you explain what kind of access they have and how you use those facilities?

A First of all, we have one ward which we use for the detoxification of patients who are multiple problems or patients who come into the program who are homeless, and they are people who we feel need some support during stailization. We also treat on a daily basis

about 60 patients who, for one reason or another, find it difficult to meet the clinic hours, or patients who have had problems in the clinics, patients who are being detoxified who I personally like to follow and have some contact with.

Q Dr. Lowinson, how many separate clinics does the Bronx State program have?

A We have seven plus the small clinic I described of 60 patients.

Q Can you give us some idea where they are located? You don't have to give the exact street addresses.

A We are in the southeast Bronx. We are in a State building where they have a welfare center on Melrose Avenue and we have two at Bronx State.

Q Now can you describe how these clinics are staffed? Do you have a standard clinic staff, for example?

A Yes.

Q Can you describe what that staff consists of?

A We have a physician who is the unit director for each clinic, a full-time physician. We have an OPD supervisor.

Q What does that OPD supervisor do?

A He is responsible for the general running of the

clinic and for supervision of the non-professional staff; four counselors and a vocational counselor; an educational therapist; four nurses; one or two utility aides; a secretary; a clerk-typist; a security guard and a porter.

THE COURT: This is at each clinic?

THE WITNESS: Yes.

THE COURT: Can you give the number of nurses?

THE WITNESS: Four nurses.

THE COURT: Four nurses?

THE WITNESS: Yes.

THE COURT: Did you say four counselors?

THE WITNESS: Four counselors.

THE COURT: And four nurses?

THE WITNESS: Yes.

Q Did you mention a social worker?

A We are in the process of hiring a social worker for each clinic; yes.

Q Now, in addition to medication, can you describe what services these staff members deliver to patients?

A Well, we try to evaluate the patients in terms of their real problems. We think that it is more important at the outset to help any person improve his housing situation, if this be his problem, to help him to get a job. If he is not skilled, we think it is important

to help him obtain training.

If he has severe emotional problems, he is seen by a psychiatrist.

The educational and vocational training portions of the program are --

THE COURT: I can't hear you.

A (Continuing) The educational and vocational portions of the program are considered very important. So many of our patients really have been deprived in these areas.

Many of them come with a deplorable history and no work history at all.

For example, at the time of admission, 33 per cent of our patients are working --

THE COURT: At the time of admission? You see, we have got a problem here. We have got more problems with hearing than usual.

Your voice is a little soft, and we have got that construction work going on in the courtyard.

If you could turn to the lawyers and talk just as slowly as you can, and if the lawyers can't hear you, then they can come up and sit in the jurybox. That might be the best thing.

I know you have got a cold so I don't want to

tax you, so do your best.

At the time of admission how many are working? You gave me a percentage.

THE WITNESS: 33 per cent are working when they come into the program.

And after one year --

THE COURT: But the others are not so they need help?

THE WITNESS: They do need help.

After a year of this treatment, the average is 60 per cent employed.

BY MR. BALBER:

Q You mentioned that you have educational services. Can you describe what kind of educational services provide?

A We have remedial education which helps patients who have not graduated from high school to obtain their diplomas.

Patients who have their college diplomas are evaluated for further education.

We have something over a hundred patients, over 5 per cent of the patients, who are now in college.

This includes patients from the southeast Bronx where the general educational level is really quite low.

Q Dr. Lowinson, in addition to these vocational

services and educational services, do you provide any family therapy in the program?

A Yes, we do. We have family meetings for patients who are initially in treatment.

In an effort to help the families to understand what it means for someone to be on methadone maintenance, and also in recognition of the fact that many families, many spouses, mothers, et cetera, have a great deal of ambivolence about keeping their addicted family member dependeng on them so that --

THE COURT: What was that?

THE WITNESS: Dependent on the rest of the family.

THE COURT: I see.

Q Do you have group therapy for patients with special problems?

A Yes, we do.

Q Can you describe what these groups are like?

A We have some groups which are really more in the nature of rap sessions where common problems are discussed.

Many of the patients really don't understand what it means to go out and look for a job, how they handle an interview.

Some very simple problems they cannot handle, so this would be a general rap session.

And then we have some psycodynamically oriented groups which get into some of the underlying conflicts that patients may have.

Q Do you make any attempt to engage patients in recreational activities?

A Yes, we do.

I'm sorry that I omitted that.

We have an active recreational program. We conduct trips. We take patients to museums, to the theatre, to concerts. There is a rather diversified program for them.

In the summer we take them on outings, on picnics --

THE COURT: Do you have any recreational facilities in your clinics?

THE WITNESS: Yes. Well, not in the clinics; we have recreational facilities in the hospital.

THE COURT: What facilities are they?

THE WITNESS: Well, we have weightlifting, punching bags, rowing machines, exercise machines.

THE COURT: Do they use those much?

THE WITNESS: Yes, they are used rather extens-

ively.

THE COURT: By the methadone patients?

THE WITNESS: Yes. We also have an occupational therapy shop which has some very fine equipment in it.

BY MR. BALBER:

Q Do your clinics deliver any services related to general medical problems as opposed to simply drug addiction?

A Yes, of course. The patients get a complete medical workup on admission and periodically.

If any medical problems are picked up at the time of admission, patients are, where possible, where we can give the follow-up care, our physician will do it. Where it is felt that he needs a more extensive specialized workup, he is sent to a clinic, either at Jacobi Hospital or one of our other backup hospitals.

Q Now, do you monitor patients with chronic medical problems like diabetes or cardiac conditions, and so forth?

A Yes. They are seen more regularly by the physician.

Q I assume that most of the services you described are delivered at the clincis.

In addition are there auxiliary services made available that are not on the clinic site?

A There is the inpatient service which is available to patients who develop problems on the outside.

There may be simply a question of a psychiatric problem. Rare as it may be, somebody who is on methadone may just have a problem and he would be admitted to the hospital for a few days or a week, or however long is necessary.

Q Dr. Lowinson, there has been testimony in this case that methadone patients sometimes congregate in and around clinics for the purpose of exchanging pills, for example, and other illicit substances.

Have you ever witnessed this type of congregation in or around your clinics?

A On rare occasions.

Q Now, do you have a program policy that you effectuate when this congregation is observed?

A We have a very firm policy about that.

When we observe this kind of activity, we discharge the patient from the program. It is a bad example to other patients.

Q Now, what percentage of your patients are involved in this type of thing?

A I would say very small. It's 1 per cent. Those patients who are engaged in such activity stand out. The good patients kind of fade into the background; you don't see them.

Now, you testified earlier about your success in the early days at Beth Israel. Can you give the Court some idea of what proportion of your patients, of the patients in your program at the Bronx State facility, cease the use of drugs after six months of treatment?

A By "the use of drugs" I assume you mean heroin?

Q No. Well, let's break it down then.

How many cease the use of heroin?

A I have some figures here which indicate that 93 per cent of the patients will have stopped using heroin after six months of treatment.

These figures are based on urinalysis.

THE COURT: 93 per cent what?

THE WITNESS: Will have abstained from using heroin.

THE COURT: After what period of time?

THE WITNESS: This is after a year. 93 per cent after six months; 94 per cent after a year.

THE COURT: What does that mean? Complete? Absolute? You mean there is no indication of heroin in

the urine specimens?

THE WITNESS: That's right.

THE COURT: Total?

THE WITNESS: Right.

THE COURT: Total absence?

THE WITNESS: Right.

Q Now, of what clinical significance is it for that other 6 or 7 per cent that are continuing to use heroin? What physical effects are they receiving from it.

A Well, the fact that we say some of them are continuing to have positive urines does not mean that they use heroin on a regular basis.

If they have already been stabilized on methadone, taking a shot of heroin is not going to change his state. It is not going to produce any euphoria. Patients may have a sense of guilt about having used heroin but they usually don't get much pleasure out of it.

THE COURT: If somebody was on methadone and he decided to use heroin, and he said to himself, "Well, I will wait and let this dose of methadone wear off," and he waits 42 hours or 72 hours or something, and then he takes heroin, do you have the blockage then?

THE WITNESS: Well, it's not so much a blockage as a tolerance. I have had patients report to me that they did not take their Sunday dose of methadone, that they left their house overnight, and they didn't have their methadone with them, and so they used heroin, and to their surprise, they did not get any particular high out of it.

I have heard patients say that they may get a slight rush for a moment, but it's over in a moment, and it's -- they don't get high.

THE COURT: I suppose it would be possible to let the methadone go long enough, wouldn't it?

THE WITNESS: Well, if somebody is away from the clinic for 72 hours, then we would begin to have some concern and try to locate that patient.

THE COURT: Just as a matter of just as far as --

THE WITNESS: The pharmacology of it is concerned?

THE COURT: Could you simply stop methadone and would there come a time when whatever the effect is wears

off, the cross tolerance, and then you could get what you were accustomed to from heroin?

THE WITNESS: I would say yes, that is so, but the reports they have got from patients have been that after a period of three days, if they take a shot of heroin, they don't get the high that they anticipate. I would attribute this to the very poor quality of the heroin on the street.

THE COURT: I used blockage, you used cross tolerance. I thought blockage was a term --

THE WITNESS: I think that we used it pretty much in the same way.

THE COURT: All right.

THE WITNESS: I think some physicans object to the term block, because block has a different meaning, a narcotic antagonist like cyclasese presumably blocks the effect of another narcotic, whereas with methadone, you develop a high level of tolerance which gives you a cross tolerance.

THE COURT: If I could divert for one minute, despite all the proof, I am not clearly sure I understand what heroin does.

Can you tell me, without going into the pharmacology in very much detail, but what happens to a person when he takes heroin? Over what period of time?

If you could just describe in general the heroin effect, what the person feels, how long it lasts, and so forth.

THE WITNESS: I think in the early days of using heroin or the early months of using heroin, there is created a feeling that some patients describe as something like nirvana. There may be a little drowsiness if someone is at rest, although interestingly enough, someone who has taken heroin, if he becomes activated, can function quite well.

THE COURT: You take heroin with a needle, right?

THE WITNESS: Right.

THE COURT: Let's take the person who is not a long-time addict. He shoots heroin with the needle. What does he feel then?

THE WITNESS: He feels, as I said, this state which he describes as being something like nirvana. It's relaxed. He becomes quiet, peaceful, maybe drowsy. Some patients, some people, when they initially try heroin, may have a very disquiet feeling. They may get nauseated and may vomit. This is not an uncommon occurrence, but this is not the primary finding.

THE COURT: Does this feeling of nirvana or euphoria, does that last a limited period of time?

THE WITNESS: Yes, heroin is a very short acting

drug, like morphine, and it lasts for only three or four hours; and for this reason patients who have become addicted use drugs four, five, or six times a day. You get mood swings with heroin.

THE COURT: You get what?

THE WITNESS: You get mood swings with heroin. For example, someone who is addicted to heroin will usually awaken with a sick feeling. He may have pains in his legs and rhinorhea, lachrymations, very uncomfortable feelings, and then he takes a shot of heroin, and it's like a graph, he is sick down here, and then he takes a shot and he is feeling high, and then after a couple of hours he begins to slip back into a state of feeling sick where he has to take another shot to bring himself up again.

THE COURT: So he will take five or six a day if he is addicted?

THE WITNESS: Right, yes.

THE COURT: I have heard it said that a person can function normally a good deal of the time, even when addicted to heroin, be a good witness or read books or do things like that, and I don't quite understand. The reason I was asking, is there a period of time of, say, a half hour where you really are feeling the effects of heroin, and then it sort of tapers off, and you could go about your

business, so to speak, and then you have the withdrawal symptoms, and then you start the cycle over again. Am I describing it accurately?

THE WITNESS: It could be described that way, but it's variable.

THE COURT: It's variable?

THE WITNESS: Yes. As you say, there are people who take heroin who are able to function quite effectively. They don't -- they just take moderate amounts, they don't get the great high, but just enough to keep themselves comfortable, so that they don't go into withdrawal, and they don't have the severe mood swings, but that is a very rare individual.

THE COURT: All right, that is where the usual situation would be where you get the high, but how long does the high last?

THE WITNESS: The high lasts for maybe 30 minutes, and then there is a continuation of a pleasant state which gradually tapers off after three hours, three to four hours.

THE COURT: Then after three to four hours, you are in withdrawal symptoms?

THE WITNESS: Right.

THE COURT: Thank you.

Q Dr. Lowinson, you gave some figures with the continued heroin abuse in your program. After the first, say, six months in treatment, what percentage of your patients have ceased abusing drugs other than heroin, barbiturates, amphetamines, and the like?

A Well, there is another 12 per cent that continue to abuse either alcohol or barbiturates or other sedative or hypnotic drugs.

THE COURT: I have got to get my figures. We are talking about after six months, right?

THE WITNESS: Right.

THE COURT: And you say you take 93 per cent and reduce it by --

THE WITNESS: Well, there is another 12 per cent whose urine show positive either for barbiturates or other sedative drugs. This does not mean that they are addicted to it or that they are using it regularly, and I don't know how different this really is from the general population.

Some interesting experiments have been done at therapeutic communities where they have taken urinalysis of the staff as well as the patients, and there has been a high incidence of positive urines in the staff as well.

THE COURT: From tranquilizers?

THE WITNESS: Yes.

THE COURT: So this other 12 per cent, what you are telling me is that I can take the 93 per cent and then subtract 12?

THE WITNESS: Right.

THE COURT: And get 81?

THE WITNESS: Right.

THE COURT: And the 81 would be free of any of this stuff, right?

THE WITNESS: That's right.

THE COURT: So you have got positive urines for barbiturates or other sedative drugs. Did you also mention alcohol?

THE WITNESS: We can't test urines for alcohol.

THE COURT: Right.

How about amphetamines?

THE WITNESS: I included that.

THE COURT: You did?

THE WITNESS: Yes.

THE COURT: All right.

What can you say about alcohol?

THE WITNESS: In terms of the incidence of alcohol?

THE COURT: Yes.

THE WITNESS: I'd say the incidence of alcoholism among our patients is about 5 per cent.

THE COURT: Well, alcoholism, let me put it this way, were you going to ask about after 12 months?

MR. BALBER: Yes, your Honor.

THE COURT: All right, then I will go back to the alcohol.

What are your statistics about these other drugs after 12 months?

THE WITNESS: After 12 months they are 94 per cent, as far as heroin is concerned, stay roughly the same after 12 months in treatment.

Q Roughly the same as the six-month figures you gave?

A Yes.

Q For heroin as well as other drugs of abuse?

A Yes. There seems to be some correlation in the increase of drug abuse with the cutting down of dose of methadone.

THE COURT: What do you mean by that?

THE WITNESS: Well, after patients have been in treatment for a year, there is an attempt to cut down on dose of methadone, and if they are feeling uncomfortable, they may take something for sleep. Usually, the primary

difficulty that a patient has when he is being cut down on his methadone dose is difficulty in sleeping. He may take some sleeping medication for that.

Even though we have positives in the urine, some of this medication is prescribed by physicians. Nevertheless, we consider it a positive urine.

THE COURT: Going back to the alcohol problem, the thing that has been presented by some of the witnesses is the possibility that if a person is on methadone maintenance and he still is of the frame of mind to turn to the same substance for depression or whatever it is his problems are, then he might go to any one of a number of alternatives, to heroin or methadone, namely, barbiturates or alcohol. In other words, the frame of mind which carried him along on heroin for a while will give him a kind of special alcohol problem. There are lots of ways you could phrase it, but you get my point?

THE WITNESS: Yes. I am not sure though that that is the case with most of the patients that we see.

THE COURT: No, I am asking you. That is what I want to know.

THE WITNESS: With many of the patients that we see, there is a prior history of drinking before they even started to use methadone, before they started to use heroin.

After they became stabilized on methadone, as you point out, they may resort to some kind of self-treatment, in quotes, and start to drink.

There is a problem with people who have used heroin and who drink in that the majority of heroin addicts have had hepatitis, so having a damaged liver, it's really not advisaible for them to ingest alcohol.

THE COURT: You can't tell anything about alcohol from the urine specimen, but what can you tell about? You want to be alert to the alcohol problem, don't you?

THE WITNESS: We make special efforts to.

THE COURT: What special efforts do you do?

THE WITNESS: The nurses and the counselors and the physician all maintain close contact with the patient, not only in the early stages but on a regular basis throughout their treatment. We try to have contact with their families and people who see them outside of the clinic as well, because while a patient may deny having an alcohol problem, may not seem that he has an alcohol problem, if he has one or two drinks a day, if he has an impaired liver, this can become a problem, so we try to get some additional in-put from the family.

We also do liver chemistry tests on a regular

basis, and liver chemistry tests are pretty good index of abuse of this sort, because of the prior exposure to the hepatitis virus.

THE COURT: You gave us a figure of 5 per cent alcoholism. Would there be something short of that alcoholism, as You define it, which might be of concern to an employer? I can see that there are a lot of variables in the degree of drinking, obviously, but there does come a point where it might become a problem to an employer, and yet the person isn't a hopeless alcoholic. I am not making it very clear, but I just wonder if you can comment on that in some way.

THE WITNESS: Well, we know that alcohol is the most serious problem to employers today in this country. The loss of time on Mondays alone of people who just are weekend drinkers is phenomenal. I am not sure of the exact figures, but it's into the billions of dollars of expenditures. So we recognize this is a serious problem.

I don't think that the problem is as serious among methadone patients as it is in general, because we are monitoring the patients on a regular basis. We are able to intervene when we feel that a problem is about to become serious.

THE COURT: Go ahead, Mr. Balber.

Q Dr. Lowinson, does your vocational rehabilitation department referred to earlier maintain referral relationships with employers?

A Oh, yes.

Q Can you describe to the Court what information this department will make available to employers about your patients when they are applying for jobs?

A We give clinical observation, the regularity of a patient in attending the clinic, keeping appointments, results of urinalysis, the kinds of progress in general that we have seen him make.

Q Do you assess patients' stability?

A Very definitely.

Q Do you describe their behavior when they are attending the clinic and so forth?

A Right.

Q Do you describe behavior you have learned about through contact with the family?

A Yes, we do, and we don't give recommendations to patients who we feel are not reliable or stable people.

Q Is your program capable of maintaining a continuing liaison with an employer regarding your patients if the employer considers such a liaison desirable?

A Whenever it's considered desirable, we do that.

Q Can you name some of the job positions that patients in your program hold?

A Well, we have patients who are holding down rather responsible positions.

Q Can you name some of them?

A Well, a supervisor at Welfare, an instructor at NYU, a supervisor at IT&T, IBM. Someone who has a rather high level --

MR. SUMMERS: Your Honor, Mr. Dunn is over there, but I would like to interpose an objection here to the testimony which describes generally without any identification of the employer, of the employee, but describes generally that we have this man here and that man there. We have no way to contest this, no way to meet that issue, and we think it's very self-serving and should be ruled out of this case.

MR. BALBER: Your Honor, if Dr. Lowinson were to name the names of specific patients, especially patients who are not part of this action, she would be commiting a Federal criminal offense.

THE COURT: I don't know why she should be naming them in general.

MR. BALBER: Because, your Honor, I think it's relevant to this proceeding, and she can describe the

patient's history, what they are like if she knows it, with what occurs at their work. That is what I intend to ask. The specific name of the patient I think is not necessary on cross-examination.

THE COURT: Why?

MR. BALBER: Well, your HOnor, it would only be relevant if during cross-examination the Transit Authority had some information about specific patients in her program that they could utilize in cross-examination, or if they intend calling these specific patients or investigating them to test the veracity of Dr. Lowinson's statements, and I really believe that that is not within the realm of reality of these proceedings.

THE COURT: In theory, Mr Summers, it could be that the Transit Authority would want to know the names of all these patients to investigate. I haven't seen the slightest indication that the Transit Authority is devoting that much energy to this case to do that kind of investigation.

MR. SUMMERS: We haven't had any opportunity.

THE COURT: You have been given the names of specific employers who have employed people from the Beth Israel or other methadone programs. I don't recall you even asking for the names. There has been nothing to

prevent you from going to Con Ed or J. C. Penney or any of the other specific employers named and asking how they are doing, and this evidence came in last fall.

I haven't had any indication that you have investigated or wanted to put in any specific evidence contradicting what was said by the plaintiffs' witnesses.

To start in at this point on something which theoretically might be valid, but as a practical matter is probably just going to sit in the record and do nobody any good, I just don't want to do that.

MR. SUMMERS: Well, your Honor, I conceive that earlier testimony to be for the purpose of showing that Con Ed does this and somebody else does that, therefore you should do it. This is different. This is saying that specific individuals are doing specific jobs, without identifying the job, the individual, the employer. This is offered for a different purpose.

THE COURT: What is the difference?

MR. SUMMERS: The other testimony, as I said, I conceived as being offered simply to show that if other employers do it, so can you, but that is not the purpose of this testimony. This is for the purpose of showing that methadone patients do specific jobs in specific areas. That was not the purpose of the other testimony as I under-

stood it.

THE COURT: Of course it is.

MR. DUNN: Your Honor, I can represent that I have in fact contacted employers as recently as the latter part of last week, and without the names it's absolutely impossible to obtain any information.

THE COURT: You had this man from Con Edison who testified on the stand. You could have asked him the names. Nobody was objecting. I don't think you even tried.

MR. DUNN: I was in contact with Con Edison as recently as yesterday, your Honor.

THE COURT: What did they tell you?

MR. DUNN: Without the names, I am unable to get any information.

THE COURT: Wouldn't they give you the names?

MR. DUNN: No, your Honor.

THE COURT: Subpoena them. That man came in, whatever his name is.

MR. DUNN: Boyle.

MR. BALBER: Excuse me, your Honor, it was doyle.

THE COURT: Doyle. This evidence, I don't remember what the record was, but I guess I can look back.

I don't want to keep Dr. Lowinson on the stand while we fight this battle out, but I think it is relevant, but did you attempt to get the names of those employees in your cross-examination of Dr. Doyle?

MR. DUNN: I don't recall that we did, your Honor, no.

THE COURT: Of course you didn't. Six months later or three months later, to call up Con Edison and say, "Please give us the names," well --

MR. DUNN: That was not the precise nature of the inquiry, your Honor.

THE COURT: What was the precise nature of the inquiry?

MR. DUNN: We had wanted to check on how the program was going with respect to employment.

THE COURT: Did you talk to this Dr. Doyle?

MR. DUNN: No, I did not. I did not.

THE COURT: He is there to talk to, isn't he? I am extremely interested in having all sides develop anything relevant in this case, but I am not particularly interested in just having material develp on the record which people will make a big point of and then drop like a lead balloon and never follow up.

I haven't seen any indication that the Transit

Authority follows this material up, and you tell me you went to Con Ed, but you didn't go to the one man who would probably feel obliged to answer your questions.

MR. DUNN: I worked through my personnel people, your Honor, and they attempted to --

THE COURT: What do you mean you worked through your personnel people?

MR. DUNN: Through the director of personnel, to obtain certain material.

THE COURT: Whose director of personnel?

MR. DUNN: Mr. Nagelberg.

THE COURT: Of what?

MR. DUNN: Of the Transit Authority.

THE COURT: He is not a lawyer on the case.

MR. DUNN: No.

THE COURT: Why didn't you call Doctor or Mr. Boyle and say, "I am the lawyer for the Transit Authority. You testified in this action."

MR. DUNN: Your Honor --

THE COURT: "Would you please give me some more information? I will serve you a subpoena."

MR. DUNN: Your Honor, Dr. Doyle testified as to the experience with a limited number of methadone patients that he had had, and the record is clear as to

what he said his experience was, and we are not refuting that.

However, in this instance we have the director of a methadone program telling us that X number, not even an X number, just that some of the patients are working at firm A, some at firm B, some at firm C, without identifying a person, giving a length of time that they were employed, and not giving us the opportunity to check with the employer to see if in fact the services performed by these people were acceptable to the employer or are acceptable, or under what circumtances they were hired, what information was furnished by the methadone program, has a program developed with respect to continuing liaison with the program.

THE COURT: In the first place, you have the right of cross-examination of Dr. Lowinson. These are all questions that presumably you will ask. It may be that we will come up to a problem because it may be you will begin asking for names. You haven't asked for any names hitherto. I don't know why you start asking for names now, but if you start asking for names now, I will have to rule on that when and if it comes, and if the cross-examination is so severely limited that it makes the direct, I will strike the direct, but I think we have to take this one stap at a time.

I will let Mr. Balber examine, but I will anticipate this much:

If the Transit Authority cross-examines you and asks you for names of employers and employees, what position will you take? I suppose you would not want to answer that really, would you?

THE WITNESS: I cannot answer that. It would be a Federal offense if I gave the name of the patient.

THE COURT: How much can You tell us without naming names and employers? How much can you tell us?

MR. BALBER: No, your Honor, I believe she can name names of employers but not the names of patients.

THE WITNESS: Right, I can name employers. I can give you some specific information about a given patient, but I can't go beyond that.

THE COURT: I think we will go as far as we can. I think it's a little late to be making a demand for names, and I am not going to cut the proof off at this point.

All right, go ahead.

BY MR. BALBER:

Q Dr. Lowinson, you said that you know of patients holding responsible positions. Can you describe in as much detail as you can a few of these patients and the kind

of positions they are holding, and where they are holding them, and any details about how long they have held them, and how they are doing, and so forth?

A I can give you the example of a young man who became -- was a Vietnam veteran who became addicted initially when he was in Vietnam. When he came back here he spent a stormy couple of years before he got into treatment. When we finally did --

THE COURT: Was he addicted during that two years?

THE WITNESS: Yes, he was.

A He was detoxified a couple of times in an effort to help him to stay drug-free. This was not successful, and he eventually entered a methadone maintenance program. After he was stabilized, he went back to college, he graduated from an excellent school in New York, and then he started job hunting.

He ran into considerable difficulty because, when a medical examination was done, it was discovered that he was on methadone. However, he was interviewed by IT&T for an important -- relatively important job for someone who is a young college graduate.

Q Can you say what this job was, without --

A A supervisor at one of their subsidiary firms.

Q What kind of a supervisor, do you know?

A He is a supervisor of about 12 people. He is a dispatch supervisor.

His employer learned about his being on methadone and called me. We had a lengthy discussion about this young man's history, about his general stability. He not only demonstrated his ability in school, he has been married, he has a stable marriage, and we felt that his general background was such that we could recommend him, and I have maintained contact with the employer, who periodically called me up to find out if this young man was doing as well as he appeared to be doing. And he has worked on this job for about a year now.

Q Can you describe some other patients? Do you have any patients who have attended law school?

A Yes.

THE COURT: Can't we get into the more manual area?

THE WITNESS: Well, one of our --

THE COURT: Operating machinery and things of that sort.

THE WITNESS: One of our first patients was a young man who had been in treatment at our hospital in the classical therapeutic community for a period of close to a

year. Every time he was discharged from the hospital he relapsed to drug use, and he was a sheet metal worker. But he was never able to hold a job because of the difficulties with drugs.

THE COURT: These were not methadone maintenance programs?

THE WITNESS: No, this was a classical program that tried to achieve a drug-free state. Patients were detoxified in the hospital and kept in the hospital where they participated in group and other therapy in an effort to help them to remain drug-free.

When this young man finally went into methadone maintenance, he very quickly got a job as a -- his older job as a sheet metal worker, which he has kept continuously. He was in our first group of patients, so that goes back to 1969, beginning of '69.

Q He has worked a sheet metal worker then for about six years; is that right?

A Yes.

Q Do you have any contacts with his employer?

A No, we don't have contacts with his employer. He was not identified as a methadone patient.

Q So the employer doesn't even know he is in your program?

A No.

Q Are there any others? We don't want to spend all afternoon with these descriptions.

Do you have maybe one additional or two additional ones that might be helpful?

A Well, there is one young man who is currently teaching at one of our local universities. He originally, when he was using heroin, he was a teacher at a high school. When he finally went into methadone maintenance, and it was discovered that he was in treatment, he lost his license, and he was unable to work there, that he is currently teaching at a local university.

He has been doing that for two years. He does that in addition to another full-time job.

THE COURT: We have had testimony by Mitchell Rosenthal and Dr. Denson-Gerber, Phoenix House and Odyssey House, and they have testified that the needs of a heroin addict for rehabilitation are mainly in the line of getting their mental habits and their life style back in shape, and the needs in order to do that are much greater than what a methadone clinic produces, and that they, namely, Phoenix and Odyssey House, have these very vigorous, extensive residential programs. They work with people for 18 to 24 months, and the main emphasis is on that kind of program.

They testified that in their view, the main emphasis in their methadone program is simply giving the medication or the drug with much, much less emphasis on the other aspects of rehabilitation, and their theory is that their tremendous emphasis on what is really important makes a more effective program. Whether that is an absolutely perfect summary I don't know, but I think that is the main point.

What I would like you to comment on is this, and I know you are head of a methadone program, so you have that view, but try to be as objective as you can, what can you say about the degree of other rehabilitation services required, and do you perform enough of them? They don't think that these methadone programs do very much, despite all the regulations and what we hear, and so forth.

THE WITNESS: Well, I have a very high regard for both Dr. Denson-Gerber and Dr. Rosenthal. However, I think the outcome of all their intensive treatment does not support their claims. I think the recidivism rate programs such as that is not significantly greater than that of some of the earlier programs at Lexington and Fort Worth. I think one of the points that was demonstrated by Gordon Chase was the fact that they had poor follow-up -- poor retention in the Phoenis House, but that they had follow-up

statistics which indicated that there was a lessening of criminal activity, but there was the singular remaining effect of the therapeutic community. There was no evidence that the patients would have been able to remain drug-free.

Q Doctor, can You identify Gordon Chase?

A Gordon Chase was the former HSA administrator.

Q City Health Services Agency?

A Yes, and so all of the methadone and other drug-free programs were reporting to him, monitored by him.

THE COURT: I guess this is an impossible question to ask you, but when you tell me about the extent of the other services performed besides the giving of the drug, is this for real, or is it kind of on a chart, or if I went up there at a busy time, would I really see people being counseled, or are they pretty much coming in and getting their drug and leaving? What are they doing?

THE WITNESS: Well, I routinely pay visits to the clincs. I drop in on the clinics at any time from 7 o'clock in the morning, and I do this unexpectedly, without appointment, because I find that this is the best way I can monitor my own program.

I can't say that a hundred per cent of the time a counselor is engaged in counseling, but there is activity with the patients. Either the doctor is seeing

patients or patients are lined up in a waiting room waiting to see him. They are waiting to see the supervisor.

We don't like to use pressure on patients, but we sometimes have to in order to get them to wait for their medical workup. We try to accommodate ourselves to the patients' hours, so it doesn't interfere with their work; and this creates intensive activity at certain hours of the day.

When the patients come in, say, in the rush hour of the morning, it's difficult for us to give that patient the kind of care that we'd like to, because he is working and he wants to get on with his job.

Nevertheless, a serious effort is made to get even the working patient to come into the clinic at a time when he can be seen by the counselor, where evaluations can be made of what is going on in his life, if he needs further counseling in vocational education, family therapy.

I can't say that is a hundred per cent, but this wouldn't be true in any kind of a medical program.

THE COURT: All right.

Q Doctor, what is your medical specialty training?

A. I am a psychiatrist.

Q Dr. Lowinson, I would just like to call your attention to one more statement as made by Dr. Denson-Gerber.

This was on page 750 of the transcript. She said:

"I believe that roughly between 1 to 5 per cent of all patients who are using drugs will be well treated by maintenance, and that the rest of the patients can live drug-free."

Do you agree with that statement?

A Well, as I say, I have a high regard for Dr. Denson-Gerber, but I think that the figures are somewhat the reverse of that. As a physician, I would like to see a patient achieve a drug-free state regardless of what kind of illness I am treating, if it's schizophrenia, drug addiction, diabetes. We all hope that we can achieve that, but it's very seldom that we can, and the recidivism rate among people who are drug-free is consistently very high, regardless of the kind of treatment they have had.

Q Dr. Lowinson, I would like to show you a portion of an exhibit in this case --

MR. BALBER: I am referring to Defendants' Exhibit EEE, I believe --

Q And after the certification to the first page which is labeled on my copy as Exhibit A, have you previously seen this?

A Yes, I have.

Q Now, this is sometimes referred to as a package insert, is it not, Doctor?

A That it is.

Q Now, are you familiar with this particular document?

A Yes, I am.

Q How recently did you examine it?

A I saw that this morning.

Q Now, Doctor, a previous witness in this case, a pharmacologist by the name of Vincent Lynch stated --

THE COURT: Do you say that you have never seen this before this morning?

THE WITNESS: Oh, no; I had seen it before.

THE COURT: Okay.

MR. BALBER: She made sure she was very familiar with it.

Q A previous witness in this case, a pharmacologist by the name of Vincent Lynch, stated that he placed a great professional reliance on the context of that insert.

Now, Dr. Lowinson, do you as a physician rely on the contents of that insert when prescribing methadone for use by your patients in a maintenance program?

MR. DUNN: Objection as to form, your Honor.

THE COURT: Yes. Sustained. I don't think that question is proper. You don't have to go back to Dr. Lynch.

The question really is, and I think that this witness undoubtedly could help us, what is the significance of a pckage insert to a clinic? Is it something or is it nothing? Do they advise prospective employers of this? What is contained in it? I don't know. There are a whole lot of questions but not exactly the one that you asked.

Q Doctor, do you rely on the side effects listed in this package insert when you are prescribing methadone to your patients?

MR. DUNN: Objection, your Honor.

THE COURT: No, I will allow that.

A I would say we go beyond this. This is a

general disclaimer that most pharmaceutical companies use for all drugs, and looking at it, it is surprising the similarity between what you would find in this and what you would find in many tranquilizers, many anti-depressants --

MR. DUNN: I object, your Honor.

THE COURT: Overruled.

MR. DUNN: I object on the further ground that the witness has not been qualified as an expert on package inserts.

MR. BALBER: I will establish her qualifications if it is necessary, your Honor.

THE COURT: I will overrule the objection.

Q Doctor, are you familiar with the Physican's Desk Reference?

A I certainly am.

Q Are these inserts commonly printed in the Physician's Desk Reference?

A Yes.

Q Is the Physician's Desk Reference used on a day-to-day basis by physicians?

A. By some physicians. I think a really competent physician would prefer to use Goodman and Gilman, or a pharmacology textbook of that character, or Avram Goldstein--

THE COURT: Would you please read the last couple of questions and answers.

(Record read.)

Q I guess my question, Doctor, is, have you examined package inserts as reprinted In the Physician's Desk Reference for other drugs?

A I have.

THE COURT: What is the Physician's Desk Reference?

THE WITNESS: It is a reference book that is published by a combine of pharmaceutical companies and it is made available to physicians.

It contains basic information, contra-indications on the indicated use for drugs, toxicologists --

THE COURT: Does it contain the material that is contained in the package inserts for the various drugs?

THE WITNESS: Yes. It is usually a reprint.

BY MR. BALBER:

Q Have you examined that reference or the package inserts themselves for a variety of drugs?

A Yes, I have.

Q Do you have some estimation of how many?

A It is hard to say. Hundreds, maybe. Anti-biotics, tranquilizers, et cetera.

Q Now, if we can go back to what you stated earlier, I believe you were stating that this description is similar to some other drugs?

A Yes, it is.

THE COURT: Which description are you talking about now?

MR. BALBER: The package insert that has been produced as a defendants' exhibit.

THE COURT: Now what about this? There were two that we were focusing on:

The one about the use in ambulatory patients and the other about the interaction with other circulatory system depressants.

THE SITNESS: I think that they don't make clear here, when they speak of use in ambulatory patients, that they are really referring to a single dose, not to people who have been stabilized on large doses of methadone.

I would agree that if a patient is taking an injection of methadone for pain, postoperatively, he should be advised to take these precautions. The same precautions do not pertain to a patient who is stabilized.

You see, these same symptoms in a drug called domethazine which is commonly given to patients with arthritis and they get dizzy, and they have feelings or

experiences of depersonalization which they are not prepared for if they are not told about it by the physician.

For the same reason, this kind of symptom is --

THE COURT: Well, now, look, have you studied this?

THE WITNESS: Yes.

THE COURT: Now, is there anything in this package insert which differentiates between stabilized methadone patients and people just taking an injection in the way you mentioned before?

THE WITNESS: There are some references In here to methadone maintenance but I do not believe that they make the distinction. Where they give the side effects they don't make any distinction.

When they talk about cinerism within the central nervous system drugs, they imply that there is a potentiation.

Now, this is something we very carefully studied in the beginning, in the early days of the program. There was a concern that if a patient were schizophrenic and he needed a feothiazine such as thorazine --

Q Which is listed in here as a drug?

A Thorazine is a drug which potentiates narcotics. In fact, it is sometimes used for preoperative procedures,

and we were concerned that there might be the same potentiating effect in patients who were mained on methadone but this does not exist. This has been verified by Dr. Dole in countless incidents.

Q But this potentiation may occur in a non-stabilized patient?

A With single doses, yes.

Q Now, with what degree of frequency does a side effect have to present itself before it is listed in the package insert?

A Presumably a single --

MR. DUNN: Objection, your Honor. The witness is neither the author nor does she edit the package insert.

MR. BALBER: Your Honor, she uses the package inserts and reprints thereof, and she is a physician and has had use of it for many years.

THE COURT: Read the question.

(Question read.)

THE COURT: I tell you what, I don't think this witness can tell us about the intention of the Food & Drug Administration in preparing the package insert.

MR. BALBER: She can tell us what she assumes as a physician when she reads that there is a side effect from a drug that is listed in the package insert.

THE COURT: She can tell how she interprets the package insert but from her standpoint of being on the other side of the insert.

MR. BALBER: Which would certainly be relevant in determining what the medical director of the Transit Authority should, as a physician, also think when he reads the package insert.

MR. DUNN: I object and ask that counsel's remarks be stricken.

THE COURT: Well, I don't know. I will allow it. It may be of some help.

Q As a physician, when you look at the package insert for a drug that you are prescribing for a patient, do you make any assumptions about the frequency of the particular side effects that are listed in the insert?

MR. DUNN: Objection, your Honor.

THE COURT: Overruled.

A I can't answer that exactly.

Presumably a side effect can be listed if it has a single occurrence. There should be extensive testing done to determine this but it isn't always done.

BY THE COURT:

Q If indeed the problems of the methadone maintenance patient were different from the problems of the one-

shot-taker, or the medicinal user, would you expect that to be stated on the package insert or don't they go into that much refinement?

A Well, they obviously haven't in this case. I think that it should be stated here that there is a distinction because many physicians are not aware of that. Many physicians are not aware of the kind of drugs that can be used with methadone.

There is an adverse reaction listed here that was not listed when it first came out. I would say it leaves somethiing to be desired.

If a physician is going to rely on this, or the PDR, he is not going to have adequate information to treat a patient who is on the methadone maintenance program.

Q Now, that package insert lists a whole variety of side effects, Doctor. Which of these side effects have you observed in your patients after they have been stabilized, let's say, for a month?

A I have seen very few. I have seen transitory skin rashes, and edema during the first month.

I have seen a case of urinary retention.

Q One case?

A Yes. And I would say some constipation.

Q And how many patients have you observed all

together?

A Well, several thousand patients.

Q Now, you stated the skin rash, the urinary retention which I assume is an inability to urinate --

A Yes.

Q -- and transitory edema -- were these conditions cleared up or were they persistent conditions?

A Oh, no. They had cleared up. The urinary retention occurred in a patient who was very anxious to retain his urine. He was out of town for the weekend and he had to be in the clinic on Monday morning, and he knew that he would be asked for a urine specimen, so he flew down from upstate and he did not urinate that morning, and this just set off a series of events with him.

Q How serious was the skin rash?

A Very minor.

Q And the edema?

A Very mild. One-plus edema of the ankles.

Q One case out of these thousands?

A No. One-plus edema of the ankles.

Q How frequently have you seen this?

A I have seen half a dozen cases of the edema.

Q What is edema?

A Edema is a mild swelling of the ankles.

Q And how long has it taken to clear up in those cases?

A Three or four days.

THE COURT: Did you mention constipation?

THE WITNESS: Yes, I did.

Q How often does constipation occur in, let's say, a patient or in patients who have been stabilized for three months?

A You are asking me for the percentage.

Q Roughly, based on your clinical experience?

A I can't give you that. I am not sure that we hear much about constipation any more than the general practitioner does, but since it is associated with nartocics, we are more aware of it, and we do recommend diet that would help to prevent it.

MR. DUNN: Your Honor, I move to have the answer stricken as not being responsive to the question.

THE COURT: Motion denied.

Q How significant a problem is the constipation? Does it interfere with --

THE COURT: We have had all this before.

MR. BALBER: All right, your Honor. I won't pursue it any further.

Q Dr. Lowinson, from your examinations of package

inserts, can you describe some of the side effects that are commonly listed from penicillin, for example?

A Well, penicillin has very serious life-threatening side effects.

Q That are listed in the Physician's Desk Reference?

A Yes.

Q Such as, for example?

A Well, you have a severe anaphalactoid reaction, a severe allergic reaction.

THE COURT: This is not going to help me.

MR. BALBER: I am only attempting to draw the analogy that for commonly used and often considered safe drugs like penicillin there are also severe side effects, just as there might be for methadone, but it would be unreasonable to assume that methadone is any more dangerous than pencillin.

THE COURT: Let's not get too far afield. Let;s stay in the area of drugs.

What about tranquilizers? Have you ever seen, in any package insert or in any Physician's Desk Reference a statement like the one that exists in our case, for use in ambulatory patients?

THE WITNESS: Yes.

THE COURT: Where have you seen that?

THE WITNESS: Well, I just named one drug. There is indomethazine or indozine.

THE COURT: And what is that?

THE WITNESS: It is a medication that is used for the treatment of arthritis, widely used.

THE COURT: Is this contained in any tranquilizer?

THE WITNESS: Yes. You will find it in tranquilizers. You will find it in antidpressants.

THE COURT: Ones that are taken and bought in drugstores?

THE WITNESS: Those that are prescribed by physicians: stelazine, thorazine, naloperidol, and all of the tranquilizers can produce this effect.

THE COURT: Do they have the warning that is given in those same words?

THE WITNESS: Whether it is the exact wording or not I am not sure, but this warning is there.

THE COURT: Well, this says "Methadone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machine. The patient should be cautioned accordingly."

THE WITNESS: Whether it is the exact wording or not I can't say, but it is close to that. It implies

the same kind of caution, the necessity for caution.

BY MR. BALBER:

Q This methadone label also contains a caution that methadone may cause orthostatic hypertension which is dizziness when people stand up?

A Well, there is no question that that exact sentence would be used with a tranquilizer, an anti-depressantor with every such medication.

THE COURT: Let me ask this question:

BY THE COURT:

Q When a package insert has a statement about the drug may be doing something, I take it that the physician is supposed to make a judgment as to the circumstances, when asked under which circumstances something may occur, and the circumstances where it won't occur, right?

A Right.

Q And then, in your judgment, does the effect stated in this use in ambulatory patients proviso, does that occur in stabilized methadone patients?

A Absolutely not.

Q Do you feel or do you advise employers of this? Do you advise patients of this?

A There is no need to advise them of that because there is no possibility of this happening in a stabilized

patient, and I think that I would agree that this should be clarified, that a distinction should be made for the benefit of treating physicians.

Q But I suppose the physician is supposed to make the distinction himself because it doesn't say that it will always happen, right? Isn't the physician supposed to make the distinction and decide what uses will cause this situation and what uses won't?

A In general. No, I think that a physician can't anticipate that this will happen, but if you give a patient, say, a phenothiazine or an antidepressant, and you tell him, "Look, you may feel dizzy if you get up too suddenly when you are sitting down, or lying down, you may have a dry mouth," then it is up to the physician to decide how suggestible a patient is. Is it better to tell him or will he develop the symptoms and then discard the drug, reject the drug because of the symptoms. So I think you have to know your patient and determine how you will handle him.

Q And you know who will distinguish between patients who are in different circumstances from the ones we are talking about, right?

A Right. But the same thing does not apply here, and I think it is unfortunate that this does not make

a distinction between the use of methadone maintenance in an ambulatory patient and the use of a single dose of methadone for pain.

You see, if you are using small doses of methadone you are going to get the same or similar effects that you get with other short-acting narcotics.

You will get the dizziness, the drowsiness.

THE COURT: I think we probably have covered that enough. We have got some more witnesses this afternoon, have we?

MR. BALBER: Yes, your Honor.

I have no further questions.

THE COURT: Any cross?

MR. DUNN: Yes, your Honor.

CROSS EXAMINATION

BY MR. DUNN:

Q Dr. Lowinson, if I understand you correctly, your methadone maintenance treatment programs that provide ambulatory or outpatient care limited to patients that have an addiction only to heroin as distinguished from multi-drug addiction?

A No.

Q Would you correct me if I am wrong, please?

A Yes.

We accept patients who have multiple addictions. However, we admit the patients with multiple addictions to the hospital so that they can be detoxified from the secondary drug use. In other words, if they are addicted to both heroin and barbiturates, they must be detoxified from the use of barbiturates. They cannor discontinue the use of that drug abruptly because they would risk running into withdrawal symptoms such as seizures or other more serious problems.

Q So that the multi-drug user or the multi-drug addict would have to experience a course of treatment, inpatient treatment for, I think you said, three weeks?

THE COURT: Let us not summarize.

Have you got anything new?

MR. DUNN: Yes, I do, your Honor, and this is important to lay the foundation for a question.

THE COURT: I remember the testimony.

MR. DUNN: I cannot identify this group without asking this question, your Honor.

THE COURT: You are repeating the testimony already given. I have a clear memory of it. Let's go on to the new question.

Q Now, the persons that have been treated as inpatients for three weeks, as multi-drug users, and then

graduating into the program, what percentage of the persons in your present program have graduated from this three-week inpatient course of treatment?

A A very small percentage of the patients are initially admitted. It is somewhere between 5 and 10 per cent. I am sorry that I don't have the exact figures are.

Q Between 100 and 200 patients?

A Overall, yes.

Q Now, you said there were seven clinics operated by your program?

A Right.

Q Can you tell me the hours or the days of the week on which these clinics are open?

A Right. In every area we have a clinic that is open at 7 a.m., from 7 a.m. until 7 p.m.

The reason for this is that we are trying to accommodate patients who work, some of whom may come in before work, and others of whom come in after work.

Actually the clinic opens at 6.30 because we have found that opening the clinic at 7 o'clock sometimes interferes with his punctuality on the job.

Q About how many days a week?

A We are open five days a week at that schedule.

Then we have an abbreviated schedule on

Saturdays. We have just changed, are just in the process of changing. We are currently open from 9 to 12, but because working patients in their first three months of treatment have to come in on a six-day basis, we are going to change that to 7 a.m. to 10 so that we can catch the working patient.

Q Where does the patient pick up his methadone on Sundays?

A He takes home his medication.

Q Are you aware of the new Federal guidelines with respect to the funding of methadone programs which require programs to be open seven days a week?

A I am.

Q A minimum of eight hours a day, five days a week, and four hours a day the remaining two days a week? Are you aware of this?

A Yes.

Q Is your program presently in conformity with these guidelines?

A We are in conformity with the FDA and the State --

Q I am asking whether or not you are in conformity with the Federal guidelines that require a program to be open seven days a week, eight hours a day for five days, four hours a day for the remaining two days?

A When a program --

Q Can you answer the question yes or no, Doctor, please?

A No, I cannot answer that yes or no. It requires some explanation.

THE COURT: You certainly have an opportunity to explain it, but what are these regulations?

MR. DUNN: They are Federal guidelines.

THE COURT: Are they in evidence?

MR. DUNN: No. They have been published in the Federal Register and signed by Dr. duPont.

THE COURT: Are they in evidence?

MR. DUNN: They are not, your Honor.

THE COURT: Why aren't they?

MR. DUNN: We haven't yet offered them, your Honor. That's the only statement I can make.

THE COURT: I don't know what it's all about. I have been working with the December '72 Federal Regulations. Have you got something newer? I think I better see it if you do.

MR. DUNN: We certainly will introduce it.

THE COURT: Do you have it in court?

MR. DUNN: I don't believe so, your Honor.

THE COURT: Do you have the CFR cite? Maybe

it isn't in the CFR.

MR. DUNN: I think it is too recent to be in the CFR.

MR. BALBER: Your Honor, unless the regulations can be identified, I am going to object to questioning the witness about them. I will have no opportunity to conduct any redirect examination about them.

MR. DUNN: The witness has already stated that she was familiar with them, your Honor.

MR. BALBER: I at least request that the witness be given an opportunity to explain what they are.

THE COURT: What are these regulations, Doctor? I guess they are guidelines.

THE WITNESS: Yes. They originally were guidelines that were set up as standards for all methadone programs. They established the number -- first of all, who is eligible for treatment.

THE COURT: Wait a minute. We have in evidence here -- I don't think I have it in the room but I am sure counsel have it -- regulations of the Food & Drug Administration which were promulgated in 1972.

Now, I was not aware until this moment that there was anything more current that that.

Now, has there been something issued more

recently than December '72?

THE WITNESS: Yes.

THE COURT: What is that?

THE WITNESS: I am not sure of the exact date on it. It was some time toward the end of '73.

THE COURT: And what are these things that came up towards the end of '73?

THE WITNESS: Well, there was a stipulation that after two years a patient's history in the program would have to be reviewed to determine whether or not he should continue in treatment.

This was one of the important distinctions. Otherwise it was pretty much the same.

THE COURT: Were there different provisions about the length of the hours and days for the clinics to be open?

THE WITNESS: I am not aware of any change. I was not really aware of the fact that clinics had to be open four hours a day on the sixth and seventh day of the week. Initially --

THE COURT: Are your clinics open seven days a week?

THE WITNESS: No; six days a week.

I think another change came about in the regula-

tions. The fact is that it is not stipulated. I am not sure, your Honor, but I think that the final regulations do not stipulate a seven-day week.

MR. DUNN: Your Honor, I think it is sufficient for the record to have the witness testify as to what her program does and we can supply the guidelines and offer them at a subsequent time.

THE WITNESS: When Methadone was a research drug, all programs had to submit a protocol.

MR. DUNN: I don't think a question has been asked about that.

THE WITNESS: Oh, I am sorry.

MR. BALBER: Your Honor, may the witness continue to explain her answer?

THE COURT: I think we will hold this subject. Dr. Lowinson has testified as to the hours and the days of her clinic. Now, if there is any problem about some new regulations, we will have to go into that, but I think it is difficult at this point, if nobody has it before him, to do that.

MR. DUNN: The regulation should have been brought in today, your Honor, and I apologize for their not being here, but they will be produced at our next session.

THE COURT: All right. Okay.

Anything else?

MR. DUNN: Yes, your Honor.

BY MR. DUNN:

Q Dr. Lowinson, are you aware of the term "Hi-dose" program as opposed to "Low-dose program"?

A Yes, I am.

Q Which, if either of these, is your program?

A Ours is a Hi-dose program.

Q Is one of your goals detoxication of the patient?

A I can't state that as a goal of treatment. Our goal of treatment is to help to rehabilitate patients.

If in the course of events it is possible for a patient to be detoxified, we certainly will encourage it.

Q What percentage of your patients ultimately are detoxified by your program?

A Well, at the present time 10 per cent of our patients who are currently being seen in the clinic are drug-free.

A large percentage -- I would say close to 20 per cent -- I don't have the dosage schedules with me -- a large percentage of the patients are currently in the process of being detoxified.

THE COURT: A large percentage?

THE WITNESS: Yes. Partly from self-motivation. The routine, the demands of the program may be too rigorous.

The fact is that a patient has to come in twice a week after he has been in treatment for three or four years, and this may prove to be a complication in his work schedule. These things drive patients out of treatment.

There are many patients who are detoxified who decide to come back into treatment, week-end treatment, but at the present time we have 10 per cent who are currently being seen who are off methadone altogether.

BY MR. DUNN:

Q Are you familiar with the metabolic theory of addiction?

A I am.

Q Will you describe for us what that is, Doctor?

A I think it should be pointed out that it is only a theory since it was developed by Dr. Dole, and since he indicates that he considers it a theory, and it has been a good working one.

I could state pretty much what he would state about it, and that is that the chronic use of narcotics creates some kind of a physiological change the nature of which has not been defined but which seems to produce

a craving for narcotics in a previously-addicted individual who is drug-free.

There is some evidence to support this in the work that was done by Martin at Lexington and by others. Previously addicted rats, rats who had been addicted to morphine, for example, who are detoxified and then exposed to morphine six months later, when given the choice between plain water and water that contained morphine in it, would choose the water with the morphine in it.

The controlled rats find this apparently unpleasant as they prefer the other. They choose the water without the morhphine in it.

Q Did Martin's experiment concern rats which were addicted to morphone or the offspring of rats who had been addicted to morphone?

A No; the rats that were addicted to morphine.

It also showed that these animals had a higher tolerance for narcotics six months later.

Q Is there a theory other than the metabolic theory of narcotics addiction that explains why a person remains addicted or goes back to the use of narcotics after having been detoxified?

MR. BALBER: Your Honor, I am going to object. This is completely beyond the scope of direct of other

witnesses today and other witness have testified at great length about --

THE COURT: I will sustain the objection.

MR. BALBER: Dr. Lowinson also has a professional engagement this evening. She has to chair a meeting at --

MR. DUNN: I am going to object to this most strenuously. The direct examination of this witness lasted an your and the cross hasn't yet begun.

THE COURT: But we do not need to go beyond the scope of the direct examination, and we do not need to repeat things that we have gone into at great length in this case.

Q I would like, Doctor, to have you describe for me the statistical studies that were performed, if any, which resulted in your conclusion -- and I think you referred to certain documents there at the time -- with respect to persons who have been in the program for a period of six months and then stated that 93 per cent of these persons had no heroin use; did you have any documents to which you referred at that time?

A. Yes. I referred to urinalyses that had been taken on patients in the program, and these are figures that are routinely prepared by the Creative Computer Company,

the Sociomedic Corporation is the name of it.

Here are patients who have been in treatment for 24 months:

6. This is a much lower percentage, actually. Actually the figures would be more convincing.

But here are the figures that a used:

12 to 24 months: Six patients had morphine in their urine out of 99.

This is really six urines out of 387.

I am saying that it is six out of 99 patients.

Q How many patients are included in this study?

A 1400 patients and 5500 urines.

Q And how many were in treatment over 24 months?

A 782.

Q Out of the 782 who were in treatment over 24 months, what percentage have urines that were negative to methadone indicating that they have not taken methadone?

A None.

Q Every one of them came back positive to methadone?

A Yes. These are all patients who are taking methadone. It does not include those who had been detoxified from methadone.

Q But wouldn't you expect, Doctor, that some of these would come back showing that the patient had skipped

taking methadone or had not taken methadone for some reason?

A I am not saying that no patient skipped taking methadone but the methadone in his urine would be --

Q I assume this is being done on a statistical basis?

A When a patient has been in the methadone maintenance program for a couple of years, I would not be surprised to find that he had -- he may have forgotten to take the medication if he is working or busy. This does not imply to me that there is any difficulty with the patient. The methadone is long-acting, and if he is not obsessed with the idea of taking his medication, he might forget it one day.

Q Now, a patient that is sustained on a dosage of 100 milligrams of methadone daily, if this patient were to take an additional 100 milligrams of methadone at the time that he ordinarily took his medication, what effect would this have on the patient?

A No effect.

Q 200 or 300 milligrams?

A. No effect.

Q 500 milligrams of methadone?

A I don't know.

Q Is there some point at which there would be an effect?

A You know, methadone is a remarkable drug in the way a tolerance is developed.

I have seen a patient take three times his usual dose of medication without showing any effect. I can't speak for others; I can only tell you what I have observed myself.

Q Would your opinion be the same if the additional 100 milligrams in the first instance were taken pararterially, by injection?

A I think there would be a difference.

Q And what would the difference be?

A I would think that if a patient had a couple of hundred milligrams of methadone, pure methadone, that he could he injected pararterially, he could get some effect from it.

THE COURT: What does pararterially mean?

THE WITNESS: Intravenously or intramuscularly.

A However, I think it is important to note that there is very -- I haven't seen any pararterial methadone in a long time, and methadone, as it is dispensed by clinics, by all programs, is in such a state that it is suspended in a viscus kind of solution which is non-injectable, and that

is also true of the tablets, the d...aphine tablets which have a coloid mixture, a coloid b... so that they can't be used intravenously.

MR. DUNN: I move that the witness' answer be stricken as being non-responsive, your Honor.

THE COURT: Motion denied.

Q Does the Eli Lilly Company sell dolaphine-hydrochloride as an injectable?

MR. BAILBER: Objection.

THE COURT: I don't know why we are starting at this hour on this subject.

MR. DUNN: Because, your Honor, this was --

THE COURT: We have had a tremendous lot of proof on things and I don't think this has anything to do with what this witness was questioned about.

MR. DUNN: The methadone patient can experience symptoms from taking additional methadone and it cannot be detected by any task presently performed by the methadone program.

THE COURT: Look, I am going to get a little technical at this point about keeping the cross within the scope of the direct examination. This is a subject which was explored indeed with some other witnesses. It was not a subject that was explored with this witness on direct

and --

MR. DUNN: The witness was asked for the use of illicit drugs. Methadone, if not prescribed by the clinic, would be an illicit drug, and I am inquiring as to whether or not the methadone patient can abuse the use of methadone, and if so, would the clinic be able to tell by any quantitative test that is performed on the urine that this patient had taken four or five, or a hundred times the dose of methadone that had been prescribed.

THE COURT: Well, not four, five or a hundred times.

MR. DUNN: The witness testified five times the amount of methadone would have little if any effect.

THE COURT: What have you got to say about that?

THE WITNESS: I have seen a patient take three times his normal dosage, and I have seen one patient who gets 150 milligrams pararterially a day. He is a manic depressive patient with a long complex psychiatric history going baack to the age of 13, and he has made many suicidal attempts.

I give you this background because it is an exceptional case. He shot himself in the right frontal lobe. He has a bullet lodged in the left occipital lobe.

He has no residual or mental deficit as a result of that.

However, he is a severely depressed patient, and he has been a chronic problem in treatment. We have hospitalzed him.

He has been in a number of different hospitals in an effort to reduce his dosage, and we have had to go to the FDA to have an exception made in his case.

We have given him 150 milligrams pararterially and we have seen no visible effect in this patient.

BY MR. DUNN:

Q Was he functional before you gave him that amount of methadone?

A Yes, he was functional.

Q Would you recommend him for employment then?

A Yes. This patient is employable.

THE COURT: Really, we are just wandering around here.

Now, we have been over two hours on this and we have not taken a recess, and I have another hearing at 5 o'clock, and how much longer are you going to be?

MR. DUNN: I have lengthy examination, your Honor.

THE COURT: On what subjects?

MR. DUNN: On the subject that the witness

was examined on.

THE COURT: Okay. So far the cross has been mainly repetitious of things we have had on the record already so we don't need that. We don't need to have Dr. Lowinson testify as a kind of general theorist.

I know that I asked some questions, and I may have some very limited questions about the general theory of things. I asked about heroin but I don't think that is particularly controversial on this issue. But the rest of the questions were mainly directed to her particular clinic.

Then there were the questions about the package insert. Now, that is basically her direct examination, and I am going to ask you to stick to that, and maybe we can conclude it quickly.

MR. DUNN: Yes, your Honor.

THE COURT: I'm sorry, I think everybody needs a recess at this point.

(Recess.)

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MR. DUNN: The doctor was gracious enough, Judge, we had a brief conversation, and she was gracious enough to at least indicate in the affirmative that if recalled she would be willing to come back, and at that time I could have the guidelines here that we referred to, or if you desire, we can proceed and see how far we get.

THE COURT: I don't want to keep her. I think in general we have got to finish this case. Those guidelines are an entirely new matter which nobody has raised until today, and that isn't just a matter of cross-examining Dr. Lowison. It affects all the clinics.

MR. DUNN: The guidelines are very recent, your Honor.

THE COURT: What?

MR. DUNN: The guidelines are within the last several weeks.

THE COURT: Why didn't you bring them up a little earlier than this? As far as I am concerned, Dr. Lowison can go right now, and I think that we will try to have the other witnesses, and I am not going to hold other sessions in this case unless it's absolutely essential, and I know exactly in advance what counsel intend to cover. The purpose of having Dr. Lowison here was to describe her clinic. This was one of the major clinics

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in the City, and it had been described unfavorably to some extent, by your witness Dr. Higgins, and we do not need to go over and over on the general theory, and we certainly don't need to have this witness for that purpose, so you can go, Doctor.

MR. DUNN: Your Honor, with respect to the FDA package insert, this was a matter of direct examination, and I would like the record to reflect that I have extensive cross-examination on that.

THE COURT: All right. I would like to hear the nature of your cross-examination about that, and we will see if she needs to return. You can be excused now. We may need to call you back, but we may not.

THE WITNESS: Thank you.

(Witness excused.)

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P A U L I N E C A R S O N, called as a witness by the plaintiff, being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. BALBER:

Q Mrs. Carson, what is your professional training?

A Three-year diploma school, registered nurse.

Q Were you previously employed by the Beth Israel Methadone Maintenance Treatment Program?

A Yes.

Q In what clinics were you stationed?

A 25th Street and First Avenue up until, I think, like the middle of '72. Then I was asked to please take over City Probation Clinic on 25th and Second Avenue, and then I had -- they asked me to go -- after I was there for a while, it was closing down because of some new regulation in the -- with the probation people.

Q Did you serve at the clinic that Francisco Diaz was enrolled at?

A Oh, yes.

Q Which clinic was that?

A 25th and First Avenue.

Q And you went there after the clinic you just described?

A No, no, I was there first.

Q You were there first?

A Yes.

Q While you were stationed at that clinic, did you have occasion to become acquainted with Mr. Diaz?

A Yes.

Q How did this occur?

A Well, just as a patient for many years. I think he -- I am not sure when he started. I think it was '69, and that's when I was first there.

Q Mr. Carson, you have been called because a number of Beth Israel Treatment Program nurse's notes pertaining to Mr. Diaz have been read into the record in this case concerning the time period between June, 1972, and February, 1973, and some witnesses have testified that you wrote these notes, and the notes note things like, "Red eyes," and "Alcohol abuse apparent."

MR. DUNN: I object, your Honor.

MR. BALBER: Your Honor, I could read from the transcript. I am trying to save time.

THE COURT: Yes, sir, overruled.

Q These notes note a number of things like "Red eyes" and "Alcohol abuse apparent" or suspected.

Did you have such notes about Mr. Diaz?

A Yes.

Q Mrs. Carson, during the time you knew Mr. Diaz, did you consider him to be a problem drinker?

A No, definitely not, not a problem drinker.

Q When you wrote these notes, did you intend to indicate that Mr. Diaz was evidencing slurred speech or other behavior that we commonly call drunk behabior?

MR. DUNN: Objection as to form. This is his own witness.

THE COURT: Overruled.

A No. If I can explain --

Q Why don't you explain exactly what context the Court should understand those notes in?

A When I made such a note, what it was for is like a signal for, for instance, this was not a usual behavior. It was unusual, as far as my note is concerned. Therefore, I write the note and say, "Hey, why does he look like this? What is happening?" To catch a behavior pattern, the possibility of a behavior pattern of falling back.

We -- or I better put I -- you look for this, any indication of a change in attitude, behavior as indicative of possibly anxiety or tension. This is what that note relates to. It isn't stating that Frank was an alcoholic. It's stating what was making him appear

this way at that particular time. What was the -- for instance, whatever happened? Was it just a night out with the boys? Was he under particular tension? Was there some problems coming up that he felt he couldn't talk to us about at the time? Because a lot of patients, they come to us with problems, but then they get to a point where they want to try and solve all their problems by themselves, and it's difficult; and they get themselves -- one little problem builds to another, builds to another, and it gets too much.

It's like being in a paper bag and trying to get your way out, so we try to catch any little changes that happen so we can, you know, what's all this about, let's get him in and talk to him.

Q So you made these notations because you thought this was unusual for Frank?

A Yes.

Q Was it your practice when you suspected that someone had a drinking problem, to recommend that some special medical procedures be employed for that person?

A Well, an out-and-out drinking problem would be very obvious. My notes, I just read them quickly before, stuporous, shaky hands, feeling of or a look and the tone of the skin, the lips, patterns in time of coming to a clinic,

change of dress, like you know they might start to look sloppy, hands dirty like they didn't take a bath, or something.

Then when they start to go into that, then you say, "There is a problem."

Q You are talking about consistent patterns?

A Consistent, yes, you would have a snowballing effect.

Q Was it your practice then to recommend that periodic medical tests, such as liver --

A Oh, yes, sure, because you have to.

Q How often on a patient you suspected was into this kindof pattern that you described were these tests done?

A Oh, every three months.

Q Did you ever recommend that be done for Mr. Diaz?

A No.

Q Mrs. Carson, during the period of time that you served at that clinic where Mr. Diaz was enrolled, did you observe his general behavior there?

A Yes.

Q What was that behavior like? What did you observe?

A Well, Frank is a very serious-minded person, takes everything seriously. He is, you know, not jovial at

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all. He is serious-minded, very polite, considerate, came for his methadone when he was supposed to.

Q Did you form an opinion as to his degree of rehabilitation or progress in treatment?

A Yes, I thought he was progressing very nicely and the whole attitude to my mind was in the change in the way that he handled things, because sometimes like they change regulation, and it was an inconvenience to working patients especially, so naturally a lot of patients would get very angry, and a lot of the patients who did not have a mature attitude would act out verbally physically.

Q Did Mr.Diaz do any of those things?

A No, he would -- he acted in what you considera-- he would get mad, but he was able to express his anger in the right manner.

MR. BALBER: Thank you very much, Mrs. Carson. That is all on direct.

THE COURT: Anything on cross?

MR. DUNN: Yes.

CROSS EXAMINATION

BY MR. DUNN:

Q I ask the witness to look at Defendants' Exhibit GGG foridentification, and tell me whether she recognizes that as a form maintained by the Beth Israel Methadone

Program relating to Francisco Diaz.

A Let's see, this would be a form kept down at the medical clinic.

Q Is it a Beth Israel form that relates to patient Francisco Diaz?

MR. BALBER: Objection, your Honor. The witness has testified it was not kept at her clinic and she was not familiar with the form. Anyone can read the notations that may be on it.

A Yes, this is not my -- it's not a clinic record.

MR. DUNN: Your Honor, this is the record that was obtained from Mr. Diaz's files when we visited Dr. Trigg earlier this week, and we are just trying to have the witness identify it for the purpose of offering it in evidence. It is in fact a Beth Israel form.

THE WITNESS: I can say it is because it says so, but what I am saying is medical records, Mr. Dunn, we have a medical clinic, and the medical records are all kept down there. Now, if this form was there, then I am sorry I don't -- I am assuming that is where you got it from.

Q It is.

A It does Beth Israel Medical Center, and it says Francisco Diaz, yes.

THE COURT: Are you offering it?

THE COURT: Are you offering it?

MR. DUNN: I am offering it.

THE COURT: There is no objection.

MR. BALBER: Your Honor, we have no objection to the form itself, but we do have objection to any questioning regarding it since this witness has no knowledge.

THE COURT: Only the form is offered.

MR. DUNN: We are discussing everything on the form, your Honor.

THE COURT: All right, received.

(Defendant's Exhibit GGG received in evidence.)

Q Mrs. Carson, you are a registered nurse in the State of New York?

A Yes.

Q Your duties at the Beth Israel Methadone Maintenance Treatment Program require you to make accurate notations with respect to your observations concerning patients?

A Yes, as best as possible, yes.

Q What does the term "alcohol abuse" mean to you?

A There are degrees -- well, degrees of alcohol abuse. Alcohol abuse means -- can mean -- well, some people, if they take one drink they get kind of reely.

Some people it takes maybe five, so it depends. I think in terms of appearance. If someone is falling against walls or falling down, uncoordinated, then that is gross abuse, and if abuse to a minimal effect could just be in a look, in appearance, you know, kind of bland, semi-elated kind of thing.

Q I show the witness Defendant's Exhibits ZZ and AAA, and I ask the witness to address her attention to a notation that appears on Exhibit ZZ dated June, 1972. I ask the witness to read it.

A Out loud or to myself?

Q I beg your pardon?

THE COURT: Read it to yourself.

THE WITNESS: Yes.

Q Do you recall the events that took place on that date?

A Well, I remember the guy who came in. He was very obnoxious, and we had to eject him from the clinic.

Can you describe as best you can recall at this date what actually occurred, what took place, what time of day it was, and from the time you first saw this individual what occurred?

A Okay. It had to be evening time. I would say after three, probably closer to five. The man came in

and he was looking for Frank.

Q Frank being Mr. Diaz?

A Yes, and we really didn't know too much what he wanted. He just wanted Frank, but he kept yelling and carrying on, something about his wife.

Q Whose wife?

A The man's wife, not Frank's wife. And we, of course, didn't tell him whether or not Frank picked up, because it's nobody's business anyway when a patient is due or not, and we just -- when he kept being abusive, we just had to have him ejected.

Q Do you know who the man was?

A No. As I said here, he said he was his brother-in-law, but we don't know.

Q Did you ask Mr. Diaz at a subsequent time if in fact that was his brother-in-law?

A His counsellor, I believe, spoke to him the next day. I don't know what the outcome was. I believe it was, but I wouldn't want to swear to it.

THE COURT: Keep your voice up, please.

A I wouldn't be sure. I think it was.

Q In addition to the narration regarding the person who you think was Frank's brother-in-law, is there a notation with respect to Mr. Diaz you saw abuse of

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alcohol?

A Yes, it said that Frank missed his medication on Thursday.

Q He missed his medication?

A Yes, that's right, which again was unusual for Frank.

Q I beg your pardon?

A Which was again unusual for Frank. Drug and/or alcohol abuse is suspected.

Q Was it suspected by you?

A Yes.

Q Why?

A Why? Well, from the look. Just his face, you know, kind of like red-streaked -- well, ss I said, red-streaked eyes, glassy-eyed look, but again we talk about degree.

Q This was suspected by you of Mr. Diaz?

A Yes.

MR. BALBER: May I ask that the witness be permitted to answer a question? He asked why, and she is explaining why.

THE COURT: Did you finish your answer?

THE WITNESS: Not quite.

MR. DUNN: I beg your pardon.

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THE COURT: Finish your answer.

A I'm sorry, I am a little nervous.

THE COURT: Take your time and finish.

A To the degree, and why I have drug and/or alcohol alcohol abuse is because it's not right to make a statement, because you cannot say drug abuse, alcohol abuse, because you cannot know until you just talk to the patient and ascertain certain tests. So actually, what I was basing it on was strictly an appearance thing to my senses and my mind without really any factual validity.

Q Were your suspicions put to rest in July, 1972, when you made an additional statement in the record?

A Okay.

Q Will you read that statement aloud for us, please?

A Sure. "Purportedly working, no essential change in behavior. Appears to forcibly smile and say everything's okay." This is what I was trying to say before, to make a note like this, and to talk to the patient, because you say this kind of thing happened in June. Now, he is kind of remaining at this same level, so what is it? What's bugging him? He's forcibly being smiling and saying, "No, no, everything's okay,"but you can see it and you know it, that not everything is okay;

you know that he is under some kind of pressure.

Q So you still had some suspicion, but not -- well, again, suspicion of --

MR. BALBER: Your Honor, may I inquire, suspicion of what?

THE COURT: Please, you let Mr. Dunn examine.

THE WITNESS: You are saying suspicion of abuse.

Q Suspicion of anything?

A Yes. Well, suspicion that he was kind of having a bad time, anxietywise, tensionwise, yes, definitely.

Q Would you read the note that you made in October of 1972? Would you read it aloud and tell us what the basis of this note was?

A "Continues to appear to abuse with alcohol and/or drugs. Not working because of back condition." Back is in quote-unquote. That is what he is saying to us, his back condition. "So far medical work-up is negative."

Q Do you recall on what you made that appraisal or what facts there were on which you based that notation?

A Well, again, with Frank it was never really physical signs -- exaggerated physical signs of abuse. With Frank it was always kind of the bloodshot-eye type of thing, not enough sleep effect, facial effect.

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Q Would you read the notation aloud in November of 1972, please?

A "Looking a little better, making more of an effort to see his counsellor."

Q Did that indicate an improvement in Frank?

A Yes, itmeant that he was to my mind coming to realize he's got to get some help, to talk things out.

Q What does the phrase mean, "alcohol abuse apparent"?

A Well, apparent is based on manifest of my senses, as far as I am concerned. It's not factually valid.

Q Is there a difference --

A It's just something that you get a feeling for from what you are seeing through prior experiences.

Q Is there a difference, Nurse Carson, in using the word "suspected" as opposed to "apparent"?

A No, I think I use those interchangeably.

Q You do?

A But I would use "appears" and "apparent" differently.

Q Would you read the notation, please, dated January, 1973, from Defendant's Exhibit AAA?

A Okay. "Alcohol abuse apparent. Bland, sad face. Has a new job. Is involved in lawsuit against

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the Transit Authority under advice of counsel for job discrimination. His aptitude was above average, but because he is on methadone, he was refused employment."

Q And what did you base the statement that alcohol abuse was apparent, if you recall?

A Well, as I said before, Mr. Dunn, with Frank it was always -- he was always net, well-groomed, clean, even his shoes. All he ever showed to me was his face, you know, like red eyes or something like that. His speech was never slurred. He never fell over things, you know, like some patients could. I never had to call a doctor for him, you know, to get a change of dose or anything.

Q Would you read for me, please, and this is the last one I will impose upon you to read aloud, the notation of April 23, 1973, which I believe is signed by you.

A "Medical clinic appointment made for him. Icteric sclera noted. Alcohol abuse continues."

Q Were each of the statements that you read either to yourself or aloud made by you?

A That I wrote here?

Q Yes.

A Sure.

Q And they were true at the time you read them?

A Yes.

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Q The first one is dated June, 1972, the last one is dated April 23, 1973. Did you at any time from June, 1972, to April 23, 1973, ask your patient, Mr. Diaz, whether or not he was using alocholic beverages?

A Mr. Dunn, what happens is, see, we are in a generic staffing kind of clinic. The nurse doesn't take upon herself to confront a patient, if it's a light suspicion. If a patient comes in, obviously, to a point where you know first you are not going to give him medication, he has slurred speech, he has all these kinds of things, then the nurse takes him right into an office, and that is to deal with that, because we are the ones that are going to have to say, "We can't give you your medication, your medicine. We are going to have to call a doctor."

Now, with Frank, when you get a patient like this, then you go to the counsellor and you say, "Gee, you know, kind of red eyes and that."

The counsellor will then take the patient in and deal with this on a one-to-one basis. We just kind of bring it up because if the counsellor is in talking to another patient or he is down the hospital or he is doing something, and he doesn't see the patient, then we bring him to them, and in Frank's case, it was with the counsellor. It wasn't necessary for us to, you know, pull

him into an office and say, "Hey, you know you can't even walk straight," or something.

Q Does the counsellor ordinarily report back to the nurse, either formally or informally?

A Well, we have like intimate meetings, staff meetings kind of thing with these kind of things discussed.

Q And when for the first time did you advise Mr. Diaz's counsellor that you suspected alcohol abuse?

A The first time I made my note would be it, because that is what you do.

Q I beg your pardon?

A I guess the first time I made my note, because that would be the procedure.

Q Would this have been discussed at that staff meeting?

A Yes, and as it turned out, I think it was a matter of having some beers.

Q Could you tell us about that, please?

A I can't tell too much, because all I know is like an outcome of Frank said he usually came towards closing time, after work, and then he would stop in and have beers, drinks, or whatever, after work.

Q You never asked Frank about that?

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A No, I personally, no.

Q Your first referral to a counsellor, you say, was in June of '72, or approximately the time of the notation?

A Yes, I would have to assume so, yes, because that is the usual procedure.

Q And the counsellor would have discussed this with you at least at a staff meeting?

A Yes, it would be brought out in a staff meeting.

Q And the first entry reflects a suspicion of alcohol abuse?

A Yes.

Q Then you say you referred that to the counsellor?

A Yes.

Q And the counsellor reported back to you at a staff meeting; is that correct?

A In general, at a staff meeting, yes.

Q And your subsequent entries state that the alcohol abuse continues?

A Yes, but we are talking about degree again, Mr. Dunn. Continues, but to what degree? What we do is alcohol, you see, the word "abuse," I am really -- I could kick myself for writing it because --

Q Why is that?

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A Because it's degree of abuse, and Frank, in my honest opinion, was not a big abuser of alcohol. He might, you know, look like he had a couple of drinks, but it wasn't like, you know, drinking at a bar, not Frank.

Q But the fact remains that --

THE COURT: We don't have to get into the fact remains. Let's not have summaries. We are very late, and I think we have got this.

Q Subsequent to the first referral to the counsellor, did you again refer Mr. Diaz to a counsellor?

A Yes. Well, the counsellor makes appointments to see the patient, and Frank pretty much kept his appointment except like around this June period, when I said -- when I made the first note too that there was something going on, which he didn't bring to us, you know.

And from there, then it was like notations are made, but they are made kind as of a guideline.

Q Did you discuss your testimony today with Dr. Trigg yesterday morning?

A Did I discuss it? No, he didn't -- we didn't go over the notes. He said they want some notes clarified that you said Frank was abusing.

Q Will you tell me what you said to Dr. Trigg and what Dr. Trigg said to you yesterday morning?

A Well, I called up first because I heard by the grapevine about --

Q How did you hear specifically?

A Through some people from the hospital who I know as friends outside the hospital, you know, and I called up Dr. Trigg and I asked him what it was about, because the people I talked to didn't really know.

Q As best you can recall, what did you say to Dr. Trigg and what did he say to you?

A Well, I said I wanted to -- once he told me that, what it was, I said, "Well, I would like to help because I wouldn't like to see Frank go down the drain because of something I wrote."

MR. DUNN: No further questions.

(Witness excused.)

mcp1

J A M E S E. C O O K, JR., called as a witness by the plaintiffs, being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. MS. DuBOIS:

Q Mr. Cook, would you tell us what your position is?

A I'm the director of JobDevelopment for the Addiction Research and Treatment Corporation.

Q Do you have job developers who work under your supervision?

A Yes, I do.

(Plaintiffs' Exhibit 56 marked for identification.)

Q I would like to show you Plaintiffs' Exhibit 56 for identification and ask you whether you are familiar with that?

A Yes, I am.

Q Are you responsible for the preparation of this exhibit?

A Yes, sir, I am.

MS. DuBOIS: To save time, I have a copy for the Court.

Q Could you tell the Court, briefly, how it was

compiled?

A Well, at the Addiction Research and Treatment Corporation each department and its department head are responsible for maintaining as comprehensive a record as possible on the activities of that department. As a result, we maintain comprehensive records on all employment activities within the job development area of ARTC.

Q Was this exhibit prepared on the basis of those records?

A Yes, it was.

MS. DuBOIS: I would like to move its receipt in evidence.

MR. DUNN: I object strenuously to the document being admitted in its present form. The identity of the employers is not shown and is not keyed in any way to the positions that are set forth in the document, nor are the job classifications and the names --

THE COURT: I don't want to make an artificial distinction because obviously we have to face the problem eventually, but Ms. DuBois doesn't have to put in the names of the employees or the names of the employers. This is information that she considers relevant and of course it is relevant. Now, the problem, of course, would be what you want to do on cross-examination and if

you can't have an effective cross, maybe the document can't go in. That is not an objection and I suppose formally I could take it and subject to a motion to strike if the cross-examination was hindered and made impossible. I think that is the formal way to do it. If you have any other objections besides the one you made, you may state it.

MR. DUNN: Essentially my objection is the inability to cross-examine or test the accuracy of the document.

THE COURT: You haven't tried to examine yet. I will receive it right now subject to any problems that we may run into on cross-examination.

Q Mr. Cook, on one of the first pages labeled "ARTC Employed Patients as of January 31, 1975," does that figure of 1801 that is next to total at the bottom represent the total number of ARTC patients now in methadone treatment?

A Yes, it does.

Q And does that include those persons who have just begun treatment?

A Yes, it does.

Q I would like to direct your attention to the next series of pages "ARTC Clients' Job Classification

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by Length of Service," which concludes at page 6 with a summary as to the number and the percentage of ARTC clients who have been in the jobs listed for the period of time there indicated. Mr. Cook, is there a system at ARTC for following up and assessing the perforance of patients once they secure jobs?

A Yes. This is part of an evaluation process that includes treatment teams input and it includes the input of the job developers and the two department leaders, the assistant director and myself. We, each of us, have to evaluate the performance of all the patients within our program and within the treatment team each patient is discussed on a regular basis in terms of what is happening to him. Each job developer makes a report as well as other members of that treatment team, the collective branches, doctors, counsellors, everyone on the treatment team must report the progress of that patient on a total program.

Q Have you talked to job developers as familiar as yourself with the performance of these patients both as to the specific job titles elicited and also the overall performance of the group of patients?

A Yes, we run regular staff meetings, that is, the job developers run regular staff meetings at which time we discuss the patients who are reported as being placed as

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well as the follow-up activity that goes on among the job developers. They have to maintain a certain follow-up schedule, you know, keep in touch with all of the patients on the job.

Q On the basis of those procedures that you go through, can you state an opinion as to the overall work performance of ARTC patients here reported?

A Yes.

Q What is that opinion?

A I wouldsay it is very good, very favorable, very encouraging. I think most important is that our patient performance is as good if not better than the average performance of people in the regular work force.

Q Do you keep records of those employees who are dismissed from their jobs?

A Yes.

Q Can you tell me approximately the percentage of employees who have been dismissed over some recent period of time?

A Well, in terms of dismissal because of dissatisfactory service, it would run from 1 to 2 per cent, around 1-1/2 per cent.

Q I would like to direct your attention to a few of the specific job titles which I will go through and

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ask you with respect to each what those employees do and how well they have performed. The first is truck-drivers at the top of the list. Can you just give the Court a general idea of the range of jobs included?

MR. DUNN: I object, your Honor, to the question.

THE COURT: Overruled.

A In the categories of the truckdrivers that are working there is a variety of services performed. There are those truckdrivers that merely drive. There are other drivers who handle sales, like drivers of soda trucks who handle sales, who do something in the way of promotion. There are other drivers who share in the loading and unloading. There are other drivers who not only handle sales but have to keep records in terms of invoices and handling of receipts, moneys, bills and what have you.

Q Do these include both interstate and city drivers?

A Yes, it does.

Q How have these truckdrivers performed?

A Very well. Very well.

Q Have there been instances of any unfavorable reports on their performance?

A No, nothing that I know of.

Q As to machinists, do you know the kinds of jobs

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any of those machinists are performing?

A Machinists that have worked and are working work primarily in machine shops that are manufacturing tools and dies and that type of thing, and they are handling lathes and drill presses, that type of machinery.

Q Have there been any adverse reports on their performance?

A No.

Q The electricians. Can you tell me generally the kind of work they are doing?

A The electricians do a wide variety of services, depending upon, you know, what particular electrician you are speaking of. One electrician may be working for an independent contractor who is doing installations. Another electrician may be doing electrical maintenance. Another one may be doing a combination of electrical services. It depends upon what contractor or what firm you are working with, if you want to be specific.

Q Is one of these electricians working for ARTC?

A Yes.

Q How are these electricians performing?

A They are performing very well. The electrician that has worked for ARTC is seen as one of the model clients within our program. He handles all of the electrical ser-

vices for ARTC.

Q With respect to the welder I note there that you only have a category "1-year plus." Can you tell me how long that welder has on the job welding?

A Two to three years. In fact, it is almostthree years.

Q Has he been on methadone during that period of time?

A Yes, sir.

Q And has he performed well?

A Yes.

Q The bus driver that appears, I think, the third from the bottom of that list, are you familiar with that person's performance?

A Yes. I know him.

Q What is your assessment of his performance?

A This is a man who is around, approximately, 40 years of age. He works for a charter service that does the resorts and recreational areas. Now he is involved in transporting groups to the ski areas. He goes to Bear Mountain in the summer. He drives for that charter service and has had considerable experience driving buses.

MR. DUNN: I object to the question and move that the answer be stricken. My ground is that the witness is

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not competent to assess the employment performance of any of these persons. He is not familiar with their employment, with the exception of when ARTC is the employer.

MS. DuBOIS: I went through it quickly in order to save the time of the Court. I and the witness established that ARTC had a regular procedure in that their job developers regularly followed up on each of the patients who are included within this report and that regularly there was a follow-up program for each patient so long as they were on the job.

THE COURT: There is a hearsay problem. There has been a lot of testimony so far and there hasn't been any hearsay objection at all, and so I have assumed that the hearsay problem wasn't being pressed.

The fact is what you actually know from personal knowledge is that the man is working, according to your records, and he has been working for how long?

THE WITNESS: The bus driver?

THE COURT: Yes.

THE WITNESS: He has been working over two years.

THE COURT: He has been working over two years. You have got him down here "8 to 12 months, bus-driver."

THE WITNESS: Yes.

THE COURT: He hasn't been discharged?

THE WITNESS: No.

THE COURT: And you have 8 to 12 months; is that right?

THE WITNESS: In this particular job situation. He has been driving a bus for over two years, but in this particular job category he has been driving almost 12 months.

THE COURT: How long has he been in the program?

THE WITNESS: He has been in the program, I think, a good three years.

THE COURT: He hasn't been discharged?

THE WITNESS: No, no.

THE COURT: You haven't observed him driving, I suppose, personally?

THE WITNESS: I have seen him, you know, with groups assembling to go to ski areas. I haven't actually been on the bus watching him drive.

THE COURT: I will take it for what it is worth.

MS. DuBOIS: With respect to when I talked to Mr. Cook before, he made clear that with respect to several of these titles I have been through he knows personally the people and with respect to others he only knows about their performance on the basis of their reports. It did not seem to me relevant to go into that report. The Transit Authority can ask him the basis on which he has

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testified that they are performing well.

THE COURT: The main thing is that they are on the jobs, and that they have the jobs. The variances as to exact performance we probably can't get into.

Do you have anything else?

MS. DuBOIS: Yes.

Q On page 3 of this section chauffeurs is listed. Can you tell me the kind of chauffeur position is encompassed, whether these are working as individuals or for chauffeur companies?

A These are for individual people. One is working for a person. He drives this lady up-State some place, she and her husband. The other one is for a businessman and he is driving him around Brooklyn all day long as he visits various sites, manufacturing sites, I think.

Q Again on the basis of your records, have you heard of any reports of bad performance?

A No.

Q On the cabdrivers, you have listed 15 gypsy cabdrivers. Is that complete?

A That is complete, yes.

Q Do you also have one client who is working as a regular cabdriver in the City?

A Yes, we do.

Q How long has that person worked as a regular cabdriver?

A A good 18 months.

Q Have there been any performance problems with any of those drivers?

A No.

Q As to the construction workers that are listed at the top of page 4, can you describe briefly the nature of the kind of construction work they are involved in?

A These men in the majority are laborers who assume a variety of roles on construction sites. When I say a variety of roles, a man is handling the movement of equipment. He may be handling the actual operation of heavy equipment. He may perform a variety of services within or on the construction site.

Q When you say "may," Mr. Cook, do you know that some of these men are performing some of those kinds of work?

A Yes.

Q The last one I want to ask you about is the tractor-trailer drivers also listed on page 4. Do you know the performance record of those two drivers?

A Yes, I do.

Q What is that?

A Very good. I know these men because there is a kind of uniqueness around these men because they do so well for themselves. They are Teamsters and they make good money and are kind of the envy of the members of the other groups. They have been on these jobs for some time. They have stimulated others to get into the Manpower Tractor-Trailer Program. The City has a Manpower Tractor-Trailer Program. These men have come through that program.

Q Just to clarify this, you have listed a partial list of employers who have hired and retained these employees. Could you tell me approximately how many employers are not included in this list?

A I guess it must be a good 80 or 85 more that are not on here.

Q Why are they not on here?

A Primarily because of the confidentiality of the patient and the employer. You see, you get a funny thing with these employers. You got a lot of job developers from a lot programs out trying to develop jobs. Once it is known that you got a client working within a given facility, then everybody is knocking on the door, so the thing that they have been able to do is to kind of protect the employer by not advertising the fact that one of our people is working and this keeps away -- keeps everybody away from

him. Of course, it works well for the client. Some of the clients dont particularly like to have it advertised that "I am a patient and I am in this program," so because of this I tended not to list everybody.

MS. DuBOIS: I have no further questions, unless, of course, the Court wants me to elicit more information about establishing his knowledge.

THE COURT: No. Any cross?

MR. DUNN: Yes, your Honor.

CROSS EXAMINATION

BY MR. DUNN:

Q Drawing your attention to the partial list of employees who have been hired and retained, ARTC patients will you name for me the employers that you have not set forth on this list who have hired and retained ARTC patients? You explained them as 80.

A You say name them for you?

Q Yes. Would you, please?

A No, I can't. I related the confidentiality of my commitment to the employer and to the patient. The whole confidentiality wouldn't permit me to name them.

MR. DUNN: I submit there is no confidential relationship between this witness and the client. I respectfully request that the Court direct the witness to

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answer.

MS. DuBOIS: Objection, your Honor.

THE COURT: What are you going to do with the information?

MR. DUNN: I won't know until I have it, your Honor.

THE COURT: I don't think we have to have that. What do you have in mind?

MR. DUNN: I have in mind having the names identified and possibly sampling some of them, sampling the ones on here.

This is another example of not being given the information and being told about confidentiality. The witness has no privilege.

THE COURT: If you want to start sampling you've got a whole group to sample. You've got Metropolitan Life Insurance Company. You've got a grocery store. You've got a detective agency. You've got Otis Elevator Company, and so sampling can be done. You've got Time & Life, St. Mary's Hospital --

MR. DUNN: It may be the ones that are not mentioned are omitted for the very reasons that they have had bad experience with the patients, and we won't know until we have the names.

THE COURT: I just picture that you won't do very much with it. You have Atlantice Ridgefield.

MR. DUNN: That is a nationwide firm. I have had the experience in requesting an organization like ITT tell us whether or not they hire methadone patients and unless you can pinpoint the name of the individual -- and it is not even clear from this as to whether the employer is aware that the individual is a methadone patient -- you can't get any information.

THE COURT: That is another subject.

MR. DUNN: May I develop something further, or at least pose a question, your Honor?

THE COURT: All right.

BY MR. DUNN:

Q Are each and everyone of these employers aware of the fact that the employees that you refer to in this document are members or participating in the Methadone Maintenance Treatment Program?

A I couldn't say for sure on that without consulting with my job developers.

Q Can you tell me --

A Do you want me to explain something?

THE COURT: I would like some explanation.

A You were asking me. Do you want me to explain

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it? You have situations here -- you have a company here where a man has been, say, working with a company and was at that company before he came to us as a client. All right. He may have been working with that company while he was on heroin, you see. Now, at the point the man goes into treatment his confidentiality becomes very, very important. Federal guidelines emphasize the confidentiality of that patient. I cannot have my job developer go to that company and say to that company, "Look, John Doe who is in that program is on methadone." So, when you say to me, "Does this particular employer know," I can't say that. I can't answer that question. I'm dealing with many, many companies. I'm dealing with many, many patients, so a specific company or a number of companies knowing or not knowing -- I can't answer that. I don't know that.

Q Which companies on this list have hired participants in the Methadone Maintenance Treatment Program and have had information furnished to them regarding these prospective employees by ARTC?

A There again I'd -- that would require some search of the records, research and so forth. For me just to outright answer that, I couldn't.

MR. DUNN: I suppose that is the very crux of the inquiry. These are the employers that we have a

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right to question, a right to confer with and see what in fact they were supplied with by ARTC and how in fact these employees have worked out.

MS. DuBOIS: Could I just go back for a moment? Dr. Prim was originally called as a court witness for ARTC. The Transit Authority has had just as much opportunity as we have had to talk to Dr. Prim and to talk to Mr. Cook and what Mr. Cook just said was that he would have to talk to his job developers. Mr. Dunn had an opportunity to ask him this and ask him about the job developers before.

MR. DUNN: I attempted to confer with Mr. Cook prior to this questioning and Mr. Cook declined to speak with me.

THE WITNESS: Your Honor, sir, this man made a statement. May I respond? I am going out of the building and this man says, "Are you a witness?"

I said, "Yes."

He said, "For whom?"

I said, "Ask the lady inside."

MR. DUNN: He shrugged and went walking by me.

THE COURT: Didn't you try to call him?

MR. DUNN: I never knew Mr. Cook was going to testify. Counsel spoke with us yesterday and today and

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Mr. Cook's name was never mentioned.

THE COURT: I think that we have a problem on this. When Dr. Prim was here the subject came up as to the employment of ARTC people and obviously if the matter can be developed properly, information about jobs done by methadone patients is of some importance. But I think we have reached a point now where we may not be able to get into the specifics of ARTC employment in this way. I think that if this exhibit is going to come in with general testimony about satisfactory employment in these specific functions the Transit Authority would have the right to come back and try to rebut it. I think it is late in the game, but this is still the plaintiffs' case and the Transit Authority would have the right to rebut and cross-examine. I don't think the Transit Authority really can.

MS. DuBOIS: They called Dr. Prim. They were the people that asked that he be put on the list. We were in the position of cross-examining. They were the people initially, weeks ago, and they could have got all the information they wanted from ARTC.

THE COURT: He didn't draw out this particular information.

MR. DUNN: We certainly didnt call Mr. Cook nor Dr. Prim.

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THE COURT: I think we are getting into the proverbial can of worms here because I just suggest that maybe we have to make do with the evidence that we have in the record about employment, which I must say is very persuasive as it is and I think we may just be creating a lot of problems to try to extend this at this point so far. I don't know exactly who asked what of Dr. Prim. We won't look back. Maybe I got into this. Dr. Prim was anxious to demonstrate the employment record. I don't know exactly how it came about.

I think it may be that I really will not use this exhibit and I apologize to Mr. Cook for that.

Mr. Cook, you would not want to be examined about the identification of all of these people, who they worked for and have counsel go into all of that detail; you are not prepared to do that, are you?

THE WITNESS: The confidentiality would restrict me.

MS. DuBOIS: He could go into more detail as to everything I asked him about. The only reason why I didn't go into detail was to shorten it, but you had indicated previously that you wanted more specific evidence about people on real jobs and the nature of the jobs.

What I would ask is that Mr. Dunn be allowed to

cp21 Cook-cross

cross-examine, go through the specific titles and ask Mr. Cook the basis of his information about them, and then the Court accept the evidence for its worth. I do not ask the Court to extend the length of the trial. Counsel should take his opportunity to cross-examine and get all relevant information. Of course, there are some employers' names that can't be given out which will jeopardize the jobs of individuals. I don't think that is relevant to what Mr. Cook is testifying about.

THE COURT: I think that I'm afraid we kind of stumbled onto this one. I don't think that anybody here really initially in calling additional witnesses particularly foresaw that we would get a list of specific jobs performed by people and the Transit Authority now says they wish to have free rein in cross-examining and have no restrictions because they want to be able to develop rebuttal testimony to inquire of the employers. This is not practical for a lot of reasons. No. 1, it is late. Secondly, the confidentiality, and, third and most important, we have been over the last few days going over the record and in my view this is cumulative and I don't think we really intended this and I think that we are creating. We have a great deal of testimony and I will say right now that it is perfectly evident to me that

wcs 1202

CARL A. BEAZER, et al

vs. 72 Civ. 5307

NEW YORK CITY TRANSIT AUTHORITY.

Before:

HON. THOMAS P. GRIESA,

District Judge.

New York, February 12, 1975;
10.00 o'clock a. m.

B E R N A R D B I H A R I, called as a witness in behalf of the plaintiffs, being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. BALBER:

Q Dr. Bihari, is this a copy of your curriculum vitae?

A It is accurate up to September 1974.

Q But is it an accurate reflection of your professional experience and qualifications until that time?

A Right, up to that point.

MR. BALBER: If there is no objection, your Honor, I would like to mark this Plaintiffs' Exhibit No. 59 to be received in evidence.

MR. DUNN: The witness stated it was accurate only up to a point, your Honor.

THE COURT: I will receive it.

(Plaintiffs' Exhibit 59 was received in evidence.)

Q Dr. Bihari, before we get to more current amendments, your curriculum vitae states that from March 1971 to June 1972 you were Chief the Drug Addiction Service, Department of Psychiatry, at the Morris J. Bernstein

Institute of Beth Israel Medical Center.

A That's right.

Q Can you explain what your responsibilities were in that position?

A I administered and supervised a 300-bed in-patient detoxification service at the Bernstein Institute for people addicted to heroin and to other drugs.

Q Your vitae also states that between 1969 and March 1971 you were Supervising Psychiatrist of that drug addiction service. What did you do in that position?

A During that period I was in charge of two of the units in that service, two 50-bed units, supervised those units, supervised the staff, examined and took care of the patients.

Q Doctor, what professional experience have you had since September 1974 that is not indicated on your vitae?

A From September through November I ran a 200-patient methadone maintenance treatment program clinic at Beth Israel; and then since November 18 I have been with the New York City Methadone Maintenance Treatment Program. On December 16 I became Acting Director; on January 6, Dictor, of that program, and am currently Assistant Commissioner of Health, City of New York, for addiction,

and Director of the New York City Methadone Maintenance Treatment Program.

Q Doctor, prior to the time that you operated the methadone maintenance clinic you just mentioned, did you have experience with methadone maintenance patients? You stated you ran a detoxification service.

A Yes. About 55 percent of the patients on the in-patient detoxification service were in fact patients from the methadone maintenance clinics around New York City who were admitted for detoxification in alcohol, barbiturates and other addicting substances and maintained on methadone. So that during that period the majority of patients that I treated or supervised the treatment of were patients on methadone maintenance.

THE COURT: I am not clear. This was February 1972 to September 1974; right?

THE WITNESS: No. From February '72 to September '74 I ran an alcoholism program.

THE COURT: Then the thing you are talking about now was when?

THE WITNESS: I was in charge of the detox service from March '71 to May '72, and for a year and a half preceding that was in charge of two of the in-patient wards in that program.

THE COURT: The March 1971 to May 1972 experience you were?

THE WITNESS: Chief, 200-bed detoxification service.

THE COURT: In-patient?

THE WITNESS: In-patient.

THE COURT: At Bernstein?

THE WITNESS: Right.

THE COURT: What did they do?

THE WITNESS: We admitted patients who were addicted to heroin for detoxification from heroin with methadone. We admitted people from methadone maintenance treatment program clinics around the city from all of the methadone treatment programs who had become addicted to other nonnarcotic drugs in the course of their treatment for detoxification from those drugs.

THE COURT: Including alcohol?

THE WITNESS: Including alcohol.

THE COURT: In other words, you admitted people who had come from methadone maintenance programs?

THE WITNESS: Right.

THE COURT: And were addicted to other drugs besides heroin or methadone; right?

THE WITNESS: Right.

THE COURT: And then what other people would you admit?

THE WITNESS: Besides those, the other 45 percent of the patients were addicted to heroin, with or without another simultaneous addiction. They were street heroin addicts who were coming into the hospital for detoxification.

THE COURT: Would they then go on to methadone programs?

THE WITNESS: Some would. Some would go on to drug-free residential programs like Phoenix House.

THE COURT: This would be that three-week detoxification?

THE WITNESS: Right.

THE COURT: Go ahead.

BY MR. BALBER:

Q How many methadone maintenance patients did you treat during this period?

A There were about six thousand admissions a year, of whom 3,500 were methadone maintenance. Treated about 4,000 methadone maintenance patients during that time, 4,000 different individuals, or supervised the treatment of that number during that period of time.

Q If we can skip ahead to the present, you say

that you are Director of the New York City Methadone Maintenance Treatment Program. When did you assume that position, Dr. Bihari?

A I became Acting Director on June 16, 1974, and was officially appointed to the position on January 6 of this year.

Q What do the responsibilities of that position include?

A That includes the clinical and administrative supervision of the New York City Methadone Program, which consists of thirty-nine clinics serving 11,500 patients in methadone maintenance treatment, with clinics located in all five boroughs of New York. The program supervises the clinical management of patients in all the clinics, even though thirty-six of the thirty-nine are administratively connected to voluntary or municipal hospitals. But the programs procedures and clinical supervision come from a central office. The payroll and certain other contractual aspects flow from the contracts with hospitals.

Q You stated, I believe, that thirty-six of these clinics are affiliated with hospitals?

A Right. The other three are run directly by the central office.

Q What roles do the hospitals play vis-a-vis the

clinics that are affiliated with them?

A The hospitals provide a conduit for the flow of funds. They provide the basic personnel policies and procedures. They provide many of the other than personnel services, like maintenance services and so on. They do much of the hiring -- actually, they do all the hiring, but the hiring for all the major clinical positions is done jointly between the hospital and the program. Individuals hired for various positions have to be acceptable to both.

Q What positions?

A Major clinical positions on which hiring is done jointly are the physicians. Each clinic has a Medical Director. You are not asking for the staff psychiatrist --

Q No.

A All of the nurses are hired jointly. The unit supervisor who is the administrator of the clinic, the assistant supervisor, all of the counselors, the mental health professionals. The only people that we really don't interview jointly are the security guards, clerks and secretaries.

Q You stated that the hospitals operate the clinics. Do you set any program standards that are applicable to all the clinics?

A Yes. We have a policy and procedure manual which we have made part of the contract, so that the hospital contracts do follow all of the policies that are spelled out in that manual. And it spells out policies in great detail.

For example, the policies which we are mandated to follow by the federal and state governments in terms of frequency of pickup of medication and the number of days of take-home medication permissible, policies like that are included in the manual. There are other program policies that relate to the rate of buildup of methadone maintenance dose; policies that relate to the management of detoxification from methadone; that relate to the frequency of counseling session, the frequency and content of the medical examinations; the mechanisms for referring patients; the definition of which kinds of patient problems need to be referred to which kinds of facilities. All are spelled out in the manual and are contractually -- and are entered into on a contractual basis by the hospitals.

Q Does this manual embody all the minimum treatment standards established by the New York State government and the federal government?

A That's right. It includes all those standards, plus the additional standards that our own program has.

Q Do you employ any procedures to ascertain whether clinics are living up to their contractual obligations?

A Yes, we do.

THE COURT: Let me just get the picture. The city has contracted with hospitals to provide these services: right?

THE WITNESS: Right.

THE COURT: You pay them to do this?

THE WITNESS: Right.

THE COURT: Do these people who come in get Medicaid benefits?

THE WITNESS: About 50 percent of the patients are on Medicaid or Medicaid eligible.

THE COURT: Of course, that provides some funding. What about the other funding?

THE WITNESS: The other funding is provided by city tax levy and 3.6 million -- our total budget is about $18,000,000. 3.6 million is provided by the New York State Drug Abuse Control Commission.

THE COURT: And the total budget is what, eighteen?

THE WITNESS: $18,000,000.

THE COURT: The breakdown of that?

THE WITNESS: And 3.6 is provided under contract with the New York State Drug Abuse Control Commission; about 6.3 million will be collected this year from Medicaid, not including the city's 25 percent contribution; the federal government pays 50 percent and the state 25 percent.

THE COURT: Wait a minute. I don't picture that. 6.3 million?

THE WITNESS: 6.3 million dollars will be the federal and state contribution to our Medicaid collections. That makes 9.9 million. And the rest, for this budget year, about a little over eight million will be provided by city tax levy funds.

THE COURT: So what you have given me includes the total reimbursement whether through Medicaid or not?

THE WITNESS: Right. The total funds for the program.

THE COURT: Total funds. What are some of the names of the hospitals, so we can get some examples?

THE WITNESS: The hospitals include the hospitals that belong to the Health and Hospitals Corporation that we have contracts with, which include Elmhurst Hospital, Bellevue Hospital, Francis Delafield Hospital, which is part of Columbia Presbyterian Medical Center; Harlem Hospital, Knickerbocker Hospital. Some of the

voluntary hospitals we contract with are Beekman Downtown Hospital, St. Mary's Hospital in Brooklyn, St. Joseph's Hospital in Brooklyn, Richmond Memorial Hospital in Staten Island, Morrisania Hospital, which is a corporation hospital; Montefiore Hospital.

THE COURT: They contract to pay the service and --

THE WITNESS: Pay the entire cost of the service. And then we collect the Medicaid.

THE COURT: Before you will contract -- I guess this happened before you came in there --

THE WITNESS: Right.

THE COURT: -- would the hospital have to comply, are there some hospitals that would simply be not of the kind that you want to deal with?

THE WITNESS: Yes. There have been -- I know that before I came there were negotiations with -- first of all, I think the program would be reluctant to contract with any proprietary hospitals.

THE COURT: Any what?

THE WITNESS: Proprietary hospitals.

THE COURT: Why?

BY MR. BALBER:

Q By proprietary, do you mean profit-making?

A Profit-making hospitals.

THE WITNESS: In terms of the nonprofit sector, I know that there were negotiations with hospitals that were discontinued because of an apparent inability on the part of the hospital to provide the proper managerial input in order to assure sound managerial practice and good administration of the clinic. Good administration is enormously important in providing quality care with methadone programs.

THE COURT: I think Mr. Balber was asking you, when I interrupted, what you do to police the hospitals.

THE WITNESS: Right. We have a central office staff who technically are called management analysts, each of whom is assigned to monitor five or six of the contract clinics. That management analyst does a number of things, which include negotiating the contract, carrying the contract into the Bureau of the Budget and moving it through the city machinery.

On an ongoing basis that person interviews all of the staff who are being recruited for positions in the clinic. That person reviews all of the vouchers for money on an ongoing basis; monitors the cash flow from the city to the hospital; monitors the clinic policies and procedures in order to assure that they are in compliance with the

programs policies and procedures; tends, responds to, calls from the staff about acute problems of various kinds which frequently end up involving certain kinds of clinical problems. When they do, they bring me in to become involved. But they are more managerial problems.

For example, sometimes there may be poor management in a clinic, because the personality of the unit supervisor, who is the primary administrator, that person doesn't have really sound management skills, and the staff is not functioning as a team. The management analyst is the person on our central office staff whose function it is to identify that problem and to bring it to our attention and to initiate processes to correct it -- termination of the staff member, if necessary. They work frequently very closely with the hospital and departments that are involved.

Q Dr. Bihari, does the work of the management analyst substitute for the activities of the New York State Regulatory Agency?

A No, not at all. What they do in fact is to assure that clinics remain in compliance with the State and Federal guidelines and regulations so when the State and Federal Regulatory Agencies inspect clinics and audit clinic procedures and the methadone employed and so on, it will be in compliance.

One of their major functions is to make sure that the clinics are in full compliance with the City and State regulations since methadone programs are monitored with extreme care and closeness by the regulatory bodies.

Q Dr. Bihari, your contracts embody standard prescribed staffing patterns?

A Yes.

Q What does that staffing pattern consist of? What staff members are required to be in attendance at the clinics?

A The basic staffing pattern for a 300-patient unit, and that is the proportion --

THE COURT: 300 patient capacity of each clinic?

THE WITNESS: No. The patients vary from

100 which is the smallest to 600, the largest, with most of them in the 200 to 300 patient range. 300 is probably the average. The pattern is calculated according to the number of patients to give us proportionates. The number per 300 patient unit would be one full-time unit supervisor. One medical director. That means one full-time equivalent position, which frequently involves two half-time positions.

One of them is given the title of medical director. It includes five nurses. It includes one senior counselor, six counselors, two assistant counselors.

THE COURT: One senior counselor?

THE WITNESS: Six counselors and two assistant counselors. The total counselors --

THE COURT: One senior counselor, six counselors. How many assistants?

THE WITNESS: Two with the title of assistant counselor. Those nine people providing counseling services. One half-time, one half or full-time mental health professional. If it is a psychiatrist, it is half time. If it is a psychologist or psychiatrist social worker, it is full-time. Two security guards. One secretary, one clerk-typist.

Q You mentioned a unit supervisor earlier.

Is that included in this group?

A The unit supervisor is essentially the clinic manager.

Q What you just described I take it is a minimum staff?

A That is a basic minimum staffing pattern with some additions.

Q Do some units in your program have staff in addition to this basic staff?

A Yes, there are several who do. In programs that has, for example, more than the average in the way of vocationally troubled patients, we add a vocational specialist. We frequently provide an additional social worker. For hospitals that have two, three or four contract units, we sometimes will contract for nursing supervisor and sometimes for an overall administrator for the four units.

Q Do you have any educational personnel in any of your clinics?

A There are no people who are designated with that title. We do have educational personnel, not on our lines who are salaried by the Board of Education in several of our clinics.

Q You said they are salaried but not in your line?

A They are paid by the Board of Education and assigned to certain of our clinics to provide education for patients. Frequently in high school equivalency level.

Q Dr. Bihari, in addition to medication, can you describe what services this staff delivers to your patients at the clinic site?

A The major areas of service besides the dispensing of medication are, number one, in the category of counseling services. That includes individual counseling which would involve counseling sessions of 40 minutes, 20 minutes to an hour at varying frequency from two to three times a week during the early period from one to two times a week for people who stabilize well.

Group therapy, family counseling, family therepy. We also provide ongoing medical serfices with a complete medical workup on admission, physical, basic laboratory work. A yearly physical exam or yearly repeat of the laboratory tests and medical diagnoses of problems that arise in the course of treatment since there is a full-time physician on staff.

When an acute or major chronic medical problem arises, they are usually referred to the backup hospital.

Q Do you provide any health education?

A Yes. In most of the clinics the nurses

provide classes and individual counseling in health education. For example, if there are a group of pregnant women, they will meet with the women on a regular basis and talk about the problems involved in prenatal care and care of the young child and counsel them about their concern for methadone and whether or not methadone will affect the baby.

We reassure them in general. They focus on their needs to make sure they are getting regular prenatal care at the backup hospital's prenatal clinic. They will be counseling about nutrition, counseling about other medical problems that patients have in common.

Q Does your staff provide any legal services to patients?

A The legal services for the most part involve counseling and referral out. Mostly to Legal Aid. A large number of our persons have come in with legal problems or have past criminal records. Sometimes they have cases pending and need counseling in terms of how to get good legal advice. We don't actually provide direct legal services to patients.

Q In addition to the services you have just described as being provided at the clinic site, are there any additional services made available to your patients

elsewhere?

A Well, I have left out one major area and that is employment counseling. A very major thrust in the program is counseling patients and trying to help them become employed, since employment seems to be possibly in addition to the medication and the counseling, probably the third major area that has a positive rehabilitative effect, so we focus a lot of energy primarily funneled through the counseling staff towards helping patients to determine their job readiness, their job preferences, helping to refer them if they need vocational testing to the appropriate agency like the Office of Vocational Rehabilitation up in New York State Department of Education.

Many of the clinics have developed working relationships with local emplohers who are, because they workclosely with the clinic, will take patients who are recommended by the clinic staff, so we do a lot of job placement as well on a local level.

Q Going back to my last question, in addition to the services provided at the clinic site itself, are there any additional services provided your patients elsewhere through your program?

A The program refers people to the Department of Social Services for public assistance or to the Social

Security Administration public assistance. It refers people to the Veterans Administration for veterans benefits. As I mentioned, legal services. We refer people out to that and for vocational services. We sometimes refer people to some of the family case work agencies like Jewish family service and Catholic charities for assistance with complex social problems.

We use the whole network of voluntary and Government-run social service agencies in New York for our patients and our staff develops a working knowledge of these resources. When they don't have that, they rely on central office specialists that know about the resources for help.

Q What types of central office specialists are there?

A We have specialists in legal services, in social services and vocational services. These are in terms of the particular areas that I am talking about. We have vocational specialists, legal and social service specialists who are familiar with the network of services in the city and train staff, know how to utilize them, provide a flow of information from central office to all 39 clinics so clinic staffs can counsel patients in the use of the resources, putting items on the bulletin boards

and so.

Q Dr. Bihari, do you know of what portion of the patients enrolled in the New York City methadone maintenance treatment program reflects the use of heroin?

A We know of six months only 4 per cent still have urine positive for morphine or quinine, so the reduction is from 100 per cent to 4 per cent. Generally that occurs within the first two or three months.

Q What occurs?

A Generally the reduction in positive urine occurs within two to three months.

Q Doctor, do you know what proportion of the patients in the New York City program sees the abuse of other illicit substances, non-opiates or at least non-heroin during the first six months in treatments?

A We screen the urine on collective random. The patients don't know beforehand whether urine is going to be collected for other major drugs of abuse, particularly barbiturates, amphetamines, cocaine and Doriden. At six months, 11 per cent of the patients run a positive, will have an occasional positive urine. During any two-month period, we collect the data I am referring to in two-month periods so each patient will be identified as to whether or not he had a "dirty urine" during that two months and during

any two-month period after six months in the program, 11 per cent of patients have a so-called "dirty urine" for one of these other substances.

THE COURT: How do you work on alcohol?

THE WITNESS: The determination of alcoholism is a clinical determination and probably the nose. The nurses smell patients when they come in to pick up medication. The patient has to lean over to sign a form in order to indicate, identify himself and indicate that he has picked up that day's medication. When he does, he has to lean over and breathe in the nurse's face and that is used as primary screening device for alcohol.

THE COURT: If somebody comes in with alcohol on their breath regularly --

THE WITNESS: It is not the only clinical device but it is probably the first line and if somebody comes In with alcohol on his breath in the daytime more than once, the nurse brings that to the attention of the doctor and the patient's counselor.

The other tools that are used are the counseling itself. The counselors always ask about the abuse of alcohol and patterns of use of alcohol we strongly urge are patients to be abstinent from alcohol.

THE COURT: Completely?

THE WITNESS: We generally urge our patients to remain completely abstinent. We do not consider social drinking an abuse but methadone patients as drug dependent people in general are a little more at risk with alcohol than the general population, so we focus on that a little bit more than we would in say the general psychiatric population.

THE COURT: Do you have any figures you can give us or any idea of the percentage of what you call alcohol abuse?

THE WITNESS: 6 per cent of our patients, with our most recent two-month report. 6 per cent of the patients were identified as being alcoholic. This is in terms of alcohol on their breath and will include some people who are showing some deterioration in liver function tests.

THE COURT: 6 per cent you said alcoholic.

THE WITNESS: Yes.

THE COURT: What do you mean by that? There are all degrees of use of alcohol.

THE WITNESS: We define it primarily in terms of whether the person's problem is a drinking problem. Whether it affects their functioning, their sociological, vocational functioning and we essentially make the assump-

tion that if somebody comes in to pick up their medication with alcohol on their breath, that that is somebody who is high likely to be drinking alcoholically.

Q Dr. Bihari, let's clear up the percentages a little bit. You said 4 per cent continues to show use of heroin after six months?

A Yes.

Q And 11 per cent of other drugs?

A Yes.

Q Is the 11 per cent in addition?

A Yes.

Q The 6 per cent of alcohol, is that in addition to that other?

A Right. That would make a total of 21 per cent of patients who are at any one point in time, 21 per cent of the current population are abusing other drugs including alcohol.

One of the things I think of distinction -- I will leave it there.

Q Is there any change after 12 months in treatment?

A For the most part, the amount of drug abuse levels off except for the heroin abuse which contineus to drop. After 12 months and 24 months, the number of

positive urines for heroin in people who are stabilized drops to about 2 per cent range.

Q How about the other drugs?

A The other drugs remain essentially stable. At 12 months, 24 months, the figures are about 10 per cent combined. For alcohol it is about 5 to 7 per cent. The decline in drug abuse occurs primarily within the first six months and by six months we could identify those people who are going to remain on an ongoing basis some drug abuse problem and identify the other 80 per cent that are not. That remains fairly stable after six months.

Q Doctor, I would like to show you an exhibit in this case, I believe it is Defendants' Exhibit HHH which are Federal funding criteria. Proposed Federal funding criteria.

Are you familiar with these criteria?

A I just received a copy from somebody recently. I was not sent a copy originally since our program receives no direct Federal funding and our program will not be required to follow these regulations, but I did want to look at a copy to try to identify it for the concerns here.

Q I would like to call your attention specially to Section 1402.01 where it states, and you can read it yourself -- it states that it applies to all programs

operating under Federal contract or grant.

A Right.

Q Is Medicaid interpreted as a Federal grant?

A No, it is not.

Q Or a Federal contract?

A No, it is not.

THE COURT: Are these not in effect?

MR. DUNN: These have been published in the Federal Register by the Special Action Office or Drug Abuse Prevention. The date for comment was January 22 and I assume they will very shortly publish them.

THE COURT: Do they apply for instance to the Bronx Day Program?

MR. DUNN: Not at the present time.

THE COURT: Would they if they came into effect?

MR. DUNN: Yes.

MR. BALBER: No, they would not and Dr. Lowinson was not questioned about it by the Transit Authority so we didn't bother about it. As far as Dr. Lowinson's program she receives no direct Federal grants. The only Federal money she receives is through Medicaid as in Dr. Bihari's program which is not involved within the scope of the program.

I communicated yesterday with counsel for the

promulgating agencies and was told that the agency did not know when they would be finalized, did not contemplate the finalization in the future.

MR. DUNN: These were offered as proposed Federal guidelines.

THE COURT: The other day you didn't talk about them being proposed. You asked Dr. Lowinson if she knew about the guidelines.

MR. DUNN: The guidelines for Federal funding. If there was confusion, I apologize.

THE COURT: All right, I think it is cleared up.

BY MR. BALBER (Continuing):

Q Dr. Bihari, are you familiar with the term package insert as it is applied to various medications?

A Yes.

Q When you as a physician are prescribing a drug, do you rely on that drug's packaged insert to inform you of the side effects that might accompany that drug's use?

A It would be poor medical practice to rely on the package insert.

Q Why is that?

A The package inserts in general seem to be designed to cover the manufacturer with regard to just about every possible kind of liability, so they will include refer-

ence, frequently, to side effects that are not genuine side effects of that particular drug.

For example, with antibiotics. These package inserts always warn about the possibility of bone marrow depression. One particular antibiotic was made to produce some bone marrow depression. If the physician used the package insert with antibiotics and was concerned about bone marrow depression, he wouldn't give anybody anitbiotics.

The only sound medical practice is to keep informed about the genuine side effects, the clinical side effects by following the medical literature closely and the medical literature in the case reports and collected aggregate reports by physicians covering the effects of new drugs which are more reliable and clinically meaningful.

Q Are you familiar with the package insert for methadone hydrochloride?

A Yes.

Q I would like to show you a section of Defendants' Exhibit EEE, specifically it is a subexhibit labeled A. I believe that has been identified previously as the current methadone package insert?

A I believe so'

Q Have you previously examined that package insert?

A Yes.

Q When did you examine it?

A This morning or afternoon.

Q Did you read the entire insert?

A Yes.

Q In your opinion, Doctor, does that insert accurately describe the side effects that may accompany some uses of methadone?

A Yes, it does.

Q What uses of methadone would that be?

A The side effects and adverse reactions that describes -- actually this is better than most package inserts. It describes fairly accurately, and in a clinically useful fashion, the side effects a prescribing physician should be aware of when prescribing methadone in single doses as a pain-relieving agent.

Q How large would those doses be?

A From 2.5 up to 10 milligrams a day when used by mouth.

Q Over what kind of a time period are you talking about?

A A single dose can be repeated up to every four hours. Maximum usually four times a day. That would be 2-1/2 to 10 milligrams up to four times a day over short

periods of time and this is a very distinct use of methadone which parallels the use of morphine and Demerol as a potent pain relieving agent for people with serious major pain.

Q In your opinion, Doctor, does this insert accurately describe the side effects observed in persons who have been stabilized in ambulatory methadone maintenance treatment?

A No, it doesn't. It bears very little relationship -- only in two or three places does it refer to what can be expected in people on methadone maintenance. In fact, in reading through the insert, I was a little troubled because of the failure of whoever wrote it to distinguish between the very distinct pharmacologic effects of methadone when used in single doses for relief of pain and when used in daily doses, much larger doses on a regular daily basis in a stabilized fashion.

The pharmacological effects and medical effects are entirely different when the drug is used in that fashion and the side effects are very different and there are a number of instances in here in which the side effects identified have no relationship at all with the side effects that one would experience with methadone in a maintained fashion. And it is like almost two different

drugs in terms of its effects on the body and the insert fails to clearly delineate that.

Q I would like you to direct your attention specifically to the heading entitled I believe "Use in Ambulatory Patients".

In your opinion, Doctor, does that particular statement accurately reflect the side effects observed in ambulatory methadone maintenance treatment?

A No, it bears no relationship to the side effects in methadone maintenance treatment when it is ambulatory. It seems rather to refer to people who are given methadone in single doses for pain relief when they are ambulatory rather than hospitalized. The terms seem to be referring to the non-hospitalized patient who is getting methadone as a pain relieving or analgesic medication.

MR. BALBER: Thank you very much, Doctor.

CROSS EXAMINATION

BY MR. DUNN:

Q What percentage, Dr. Bihari, of patients admitted to medical programs would you describe as being addicted to alcohol?

A On addmission to the program?

Q Yes.

A It is hard to determine. Our clinical

judgment is it is around 5 to 6 per cent.

Q Were you the author of a paper entitled "Alcoholism in MMTP Patients"?

A Yes, sir.

Q Which was presented to the Fifth National Conference on methadone treatment in Washington, D.C. 1973?

A Yes.

Q Did you in that article state:

"A growing proportion of MMTP patients admitted (currently 40 per cent) are addicted to alcohol either as the only drug of abuse or combined with one, two or occasionally three others"?

A That referred to patients admitted to the hospital for detoxification, not admitted to methadone programs.

Q The statement says a growing proportion of methadone maintenance treatment program patients?

A Admitted. I think the paper made it clear I was referring to my experience as chief of the Drug Addiction Service. Admitted meant admitted to the hospital, not admitted to methadone treatment.

THE COURT: You mean admitted to --

THE WITNESS: Like the Bernstein Institute.

THE COURT: In other words, people who were

admitted from methadone programs.

THE WITNESS: To the hospital, right.

Q Going on in this paper, Doctor, the statement appears:

"In a significant minority of alcohol methadone maintenance patients, both the time course of a development of severe alcohol addiction and the quantity of daily alcohol intake is quite striking. Some patients who previously abuse alcohol in some addicting quantities begin to drink heavily enough to become physiologically addicted in three to nine months after the onset of methadone maintenance treatment compared with the five to 15-year clinical course usually seen in non-opiate using chronic alcoholics before the onset of physiological addiction. The concurrent amounts ingested are reflected in the amounts reported by alcoholic MMTP patients, admitted to our Drug Addiction Service compared with reports of non-opiate use chronic alcoholics admitted to our alcoholism treatment program in patient treatment service for detoxification. The former group" --

MR. BALBER: Objection. Obviously the article can be used to question him but to read it into the record --

THE COURT: Overruled.

Q "-- generally reports from two to four times more daily intake of alcohol than the latter group. The one drinking alcoholic MMTP patient for example often reports an intake from four to as many as 16 to 20 pints a day while the one drinking chron ic alcoholic generally reports an intake of from three to four pints a day with more than six unusual. Many heroin addicts not on methadone maintenance are alcoholic but very few drink this heavily."

Did you write this?

A Yes.

Q Was that your opinion at the time?

A Yes, it was.

Q Is it your opinion now?

A Yes, it is.

THE COURT: It was a long complicated quote and I don't really understand. What is it you meant to say there?

THE WITNESS: What I meant to say was, in a very small but clinically interesting minority.

MR. DUNN: I believe the word was in a significant minority.

THE WITNESS: Of the alcoholic methadone patient.

That is, if one took the people I referred to as representing about 6 or 7 per cent of our patient population, those that are identified as alcoholic, a significant minority of those, i.e., perhaps a quarter to a third of that group, which would represent about 2 per cent of the overall methadone patient population drink very dramatically and much more heavily and become alcholics and drink alcoholically with a much more rapid clinical course than the case with the non-narcotic using alcoholic population.

There seems to be a small group of patients with very particular psychiatric clinical syndromes who drink in massive amounts when they discontinued using heroin and that is really -- that is what that reference was to and what some of the concerns of the paper was about.

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Q You continue in this paper, skipping considerable amount, Doctor:

"Alcohol abuse, as is the case with all drug abuse in MMTP patients, always is indicative of symptoms of underlying psychosocial or psychiatric problems.

"Three general groups can be discerned.

"1. Patients with the range of psychotic illnesses seen in the nondrug dependent population, who use alcohol as an antipsychotic drug. These account for a very small portion of the alcoholic MMTP population."

Can you tell me what percentage these persons with a psychotic illness represent?

A Well, if we take the 6 percent for alcoholic, no more than 2 or 3 percent of those. That would mean we are talking about a tenth of 1 percent of methadone patients use alcohol as an antipsychotic agent.

Q Going on:

"2. Patients with ordinary situational or adjustment reactions, mild personality problems and psychosocial problems without severe psychopathology. These patients, who form a majority of the alcoholic MMTP group, for the most part, do not drink massive quantities. Like most alcoholic MMTP patients, they drink wine, but the intake is in the range of 2 to 6 pints a day.

"One common group of such problems is the truncation or arrest of normal maturational processes of late adolescence, when drug use began. Manifestations include social shyness, timidity and anxiety in the presence of sexually attractive people. There are also problems having to do with the acceptance of adult responsibilities, including the ability to take a mature role in close relationships. In many ways the 30-year-old ex-addict, who began drug use at 15, has many of the problems of the normal 15-year-old. Having these at 30 becomes a source of considerable day-to-day anxiety which many can relief with alcohol. In general, the most effective treatment approaches for problems of this nature are the varieties of group therapy."

How large a group would you say these are, the ones that, as I understand it, have the normal maturation process arrested?

A Now, you are talking about what percentage of the alcohol-methadone patients does this fit? Could you be more exact?

Q What percentage of the methadone maintenance treatment program patients--

A Patients experience --

Q --are you describing here?

A Patients with some anxiety? That was written to describe the kinds of problems that a particular group of patients have.

Q Yes.

A Right. Many heroin addicts, when they discontinue heroin use, particularly the 80 percent of patients who do well--the 20 percent who do not start using another drug--who do not become alcoholic and have discontinued using heroin, find that in the early weeks and months, on methadone maintenance, since they are no longer receiving a narcotic which is acting as a tranquillizer, relieving anxiety, relieving depression, serving as a social lubricant, find themselves feeling anxious, shy, finding themselves having to deal with situations which they didn't have to deal with when they were out on the drug scene, having to go for job interviews, having to deal with people in the so-called straight world, having sometimes to relate to people that they are in close relationships with, without the lubricating effect of heroin or other drugs.

And so the early weeks, and particularly the first three or four months, of treatment in methadone maintenance, these patients require a great deal of counseling and a great deal of support. And I try, as has been indicated before, the majority of patients quickly

deal with those problems. Because in many ways it is easier for a 30-year-old to deal with a 15-year-old's problems than for a 15-year-old to do so.

Q Meanwhile my question was, Doctor: What percentage of the methadone maintenance treatment program patients were you describing?

A I really can't answer that. You'd have to do a study to determine. I would say that it's on a spectrum with a large percentage having some of those problems, being a little shy, for example.

Q What do you mean, Doctor by the normal maturational processes of late adolescence? What are these?

A They are the processes that have to do with the development of a clear sense of who you are, that enables you to begin to relate to other people in a clear, consistent fashion.

Q What is the effect of having these processes arrested?

A Sometimes the effect is being shy with strangers, being a little anxious in job interviews, being a little anxious when one begins to undertake new responsibilities. These really are the problems not just of addicts; these are problems of -- these are not

psychiatric problems either. I think I made it clear that they were not. They are what I would call psychosocial problems. And in fact a majority of people who have been drug dependent, when they discontinue using whatever drug they have been using as a means of avoiding dealing with the world, have to deal with the world in different ways. And that really is what the counseling is about. That is why we have counselors and that is why we do individual family and group therapy with our patients.

Q What percentage of your patients do you engage in group therapy?

A About 20 percent.

Q How are they selected?

A It varies a great deal with the clinic and depends upon the skill and sometimes the charisma of the people who are running the group. That is, if the group is a group in which the people participating gain something, then other patients will ask to become involved. The groups are voluntary. Counselors will sometimes encourage patients to attend the group, and if the group is not a group that their colleagues or friends are getting something useful out of, they would be reluctant to.

Q How do you know about policing the clinics, Doctor? You describe a group that you have of inspectors or

whatever the title was.

A Management analysts.

Q Management analysts?

A Right.

Q You said each was assigned five or six clinics. How do they go about actually checking on the clinics?

A Well, could you ask me specific questions, and I will tell you how they check.

Q You tell me what they do on a day-to-day basis.

A On a day-to-day basis they visit the clinics, they examine active patient charts.

THE COURT: Each one is responsible for how many?

THE WITNESS: Five to six clinics. There are seven management analysts for the thirty-nine clinics. One of their major jobs is to examine patient charts and to -- for example, one of the things they look for is the thoroughness and adequacy of th- entrance or admission physical exam. They look to make sure that all the basic laboratory work required has been done. They look for regular counselors' notes. And they act on the assumption that if there has been a counseling session, there is a note in the chart that refers to that session, because that is

program policy. And one of the things they look for is to make sure that every patient in the first three months of treatment has at least two counseling notes per week at a minimum, and that patients, in the first six months of treatment, from three to six months, have at least one note per week.

In general, unless there has been an exception written in the chart by the unit supervisor, they look for one counselor's note per week for the first two years in treatment.

Q Do they look for nurses' notes?

A They look for nurses' notes. The nurses' notes at least once weekly. They look for doctors' notes.

Q Are nurses' notes significant at all, Doctor?

A Yes, they are.

Q In what way?

A The nurses have the opportunity to relate to patients in somewhat different way than the counseling staff, and they also have the professional training to make certain kinds of observations that other staff members can't.

For example, the nurses are sometimes the clinical staff members who first identified a drinking problem or a drug abuse problem before it shows up with a positive urine, because the nurse talks to the patient

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during the first three months of treatment six times a week, and after that, five times a week for several months longer, for some patients for the first two years five times a week. You probably know about the pickup frequency regulations. Every time a patient picks up medication, it means that he has -- required that he has a conversation with a nurse. And the nurses are trained to use that conversation, which involves very close face-to-face contact because of the signature that I described before, as an opportunity to determine whether or not the person is drug abusing. It's a major purpose of it. They also use it as an opportunity to talk to patients about current medical problems; to ask them if they have seen the doctor; to tell them that "You know, you haven't seen the counselor this week. He asked me to tell you to stop down before I give you the medication. So before you get today's methadone, I want you to see the counselor, and the counselor will let me know after the session that you have."

They do, as I mentioned, a certain amount of health counseling.

Q As a physician and as the director of the city's programs, would you lend very much weight to nurses' notes?

A Yes, a great deal on a general basis, yes.

Q Dr. Bihari, with respect to the package insert,

are you familiar with the --

A By the way, I should condition that by saying: nurses' notes in my program. Because the nurses in my program are trained to make certain kinds of observations, and because of the management techniques I described, the content and relevance of the notes are monitored. I can't speak for any other program.

Q By your program, you are referring to --

A The New York City Methadone Maintenance Treatment Program.

Q You had also been connected with Beth Israel. Does the same apply to Beth Israel?

A No. In Beth Israel I ran an alcohol program and a detox program that I referred to.

Q Weren't the nurses trained in the same instances?

A No, the nurse's functions were very different in those three contexts. The methadone nurse has a different job than the nurse working in a hospital setting --

Q I am referring to the methadone -- well, not the methadone nurse -- the nurse employed in the methadone maintenance treatment program.

A Right.

Q In which she had essentially the same training and the same awareness.

A I don't know what training the methadone nurses got at Beth Israel. You know, I really can't speak for another program, other than any program that I have run myself. If I had critical comments --

Q I beg your pardon?

A I say I really think it is inappropriate for me to speak about the quality of nursing in another program.

Q Insofar as you are aware or you have knowledge, I don't think it is inappropriate, Doctor.

THE COURT: In response to a question -- what is your question?

Q My question is whether or not you were familiar with the training of the nurses in the methadone maintenance treatment programs at Beth Israel.

MR. BALBER: Objection.

THE COURT: Overruled.

MR. BALBER: It is beyond the scope of direct, your Honor. The doctor has not talked about all the programs --

THE COURT: Overruled.

A The question is, am I familiar with --

MR. DUNN: Mr. Reporter, would you read the question, please.

(Record read)

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THE COURT: If you have some question about his knowledge --

MR. DUNN: I thought I would save time by having the last question read, your Honor.

THE COURT: Reframe a question.

Q Are you familiar with the training given to the nurses at the Beth Israel Methadone Maintenance Treatment programs?

A In general, yes. Not as familiar as I am with the training of my own program.

Q How does the training differ from the training given in your program if at all?

A From my experience of it there was not as close administrative management kind of supervision of the nursing function; that more of the surveillance occurred on the individual clinic level. And in fact that reflects a difference between the New York City program and other programs in general: that the amount of overall surveillance and administrative overseeing of day-to-day activity is considerably greater in the New York City program. And I knew the Beth Israel program, because I was working alongside of it for a long time, and it does not have the kind of tight administrative structure that the New York City program does. And the same holds true in each of the

clinical disciplines.

For example, they don't have any staff members who are analogous to the management analysts that I just described. So there is no operational unit in the Beth Israel methadone maintenance program that corresponds managerially to the group of people that I mentioned. So the ability for the central administration to closely supervise the daily activities is less. That is the major difference.

Q These management analysts that you refer to, Doctor: In the course of the past twelve months do you know how many deficiencies they found in the thirty-nine clinics that you now head?

A I really couldn't give you numbers. I know that they do bring some deficiencies to my attention. The majority of deficiencies they have had so much experience in dealing with and correcting and that are routine, that they never come to my attention. But, for example, if a chart is missing, regular counselor notes of the frequency required, they will bring it to the attention of the clinic's unit supervisor; they won't bother bringing it to my attention -- unless there is an overall pattern of deficiencies in the clinic operation that suggests generally poor management in that clinic. Then they will bring it to

my attention to deal with the mismanagement in the clinic in general.

But, you know, the small pieces of their daily -- their small daily transactions are not brought to my attention and should not be.

Q How frequently are urinalyses required to be taken of patients in the program?

A Weekly.

Q Can you name any significant deficiencies that were noted in the past twelve months by these management analysts?

A Sure. For example, in one clinic they noted a serious deficiency in the frequency of counseling notes. And I had a member of the staff speak with the clinic supervisor. The management analyst, in relation to that, also examined some of the functions of other staff members, and found that the nurses were not attending staff meetings, and that there were some tensions between nurses and counselors and ultimately discovered that the unit supervisor, who is the management person in that clinic, was a very insecure person who was playing off one group against another and was not providing genuine supervision of the staff. And that person was asked to -- was terminated and has since been replaced.

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That is one example. That comes up perhaps three or four times a year a major staff members is replaced.

Another example is that a management analyst recently brought to my attention a pattern of abuse in one clinic of the adequacy of the doctor's hours. A doctor who was being paid for 20 hours a week, who was never present when she arrived to visit the clinic, and who some staff members told her was available by phone but only showed up in the clinic two or three times a week and worked about an hour.

I talked with his supervisor, and he was asked either to increase his time and sign in and sign out, increase his time to a full 20 hours, or leave. And since he had three or four other jobs simultaneously, he left and was replaced.

There are problems like that that arise on a regular basis that the management analysts bring to my attention.

I can give you other examples if you like.

Q Please do.

A A management analyst yesterday brought to my attention the bimonthly report that we get on each clinic and get for the whole program in terms of the percentage of patients who have positive urines for various drugs, and

the percentage of patients on various doses of methadone who have positive urines. We also get in that report the percentage of people who are employed, and so on.

In one particular clinic she -- we use this kind of data as a management tool -- and one of the things she discovered was that there were four patients in a particular clinic in Manhattan who had during that two-month period had morphine in the urine, which means they were using heroin, but who were only picking up medication three times a week. And the program policy is that anybody who is known to be abusing, particularly abusing heroin, is on a five times a week pickup. So she brought it to my attention, just to let me know that she was -- because she knew that I would be looking at that same piece of data -- to let me know that she had seen it and that she was bringing it to the attention of the medical director of the clinic, to make sure that those patients who had positive urines during that period would be increased to a daily pickup schedule. That is another example.

I might expand a little bit on that. There is an enormous amount of data -- we have a very comprehensive data system -- that also is quite unique, and the other programs in the city or in the country don't have, that we use as a management tool, that allow us to monitor the

clinical activity. We are able to determine, for example, how many patients in a particular clinic are on what dose of methadone. I can tell at a moment's notice how many of the patients, of the 11,500 patients in the program, had urines positive for cocaine in the last two months of the reporting period. I can tell how many of those 11,500 patients were picking up three days a week versus four days a week versus five days a week. That kind of information is used as a means of monitoring the clinic, whether or not the clinic is following certain of the policies and procedures.

We have similar data flow in terms of fiscal monitoring, and the management analysts play a role in fiscal auditing as well.

THE COURT: What percentage of your patients are employed?

THE WITNESS: At the moment, for people who have been in treatment six months or longer, 45 percent are employed, are working at paid jobs; 11 percent are homemakers; and 6 percent --

THE COURT: Wait a minute. 45 percent --

THE WITNESS: 45 percent are employed.

THE COURT: In paying jobs.

THE WITNESS: Right, in full-time jobs.

THE COURT: All right.

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THE WITNESS: 11 percent are identified as homemakers.

THE COURT: All right.

THE WITNESS: And 6 percent are full-time students.

THE COURT: You mentioned the categories of hospitals

THE WITNESS: Right.

THE COURT: Proprietary hospitals you don't include.

THE WITNESS: Right.

THE COURT: Then there is the voluntary non-profit hospitals?

THE WITNESS: The voluntary nonprofit hospitals.

THE COURT: Like Columbia Presbyterian?

THE WITNESS: Like Columbia Presbyterian, Roosevelt -- we don't have a contract with Columbia Presbyterian and Roosevelt.

THE COURT: I thought you said you had a contract with those.

THE WITNESS: No, the contract is with Delafield, which is a municipal hospital run by affiliation with Columbia Presbyterian. But our contract is with Delafield, which means it is with the city -- with the Health and

Hospitals Corporation in that case.

THE COURT: So the voluntary nonprofit, and then the other category?

THE WITNESS: And an example would be New York Hospital. It is a voluntary hospital that we do have a contract with.

THE COURT: You have a contract with New York Hospital?

THE WITNESS: Right.

THE COURT: And then what is the other category? City hospital?

THE WITNESS: The other category is what used to be called municipal hospitals.

THE COURT: What is it called now?

THE WITNESS: We currently call them corporation hospitals, because they belong to the quasi-independent Health and Hospitals Corporation.

THE COURT: Health and Hospitals?

THE WITNESS: The Health and Hospitals Corporation.

THE COURT: Who owns that?

THE WITNESS: That is a quasi-independent corporation which is entirely funded by the city. It plays a role something like, I think, the Board of Education and

the MTA. I believe both have somewhat independent --

THE COURT: Does it have a board of trustees?

THE WITNESS: It has a board of trustees -- a board of directors, of whom the chairman is the Commissioner of Health, and five of the members are appointed by the Mayor, five of the fifteen members are in addition appointed by the Mayor, besides the Commissioner of Health, who is the chairman.

THE COURT: So five of the fifteen are appointed by the Mayor.

THE WITNESS: Right.

THE COURT: Who appoints the others?

THE WITNESS: The others are appointed by the board as they are replaced. I am really not sure.

THE COURT: A self-perpetuating board?

THE WITNESS: Yes. I am not sure who is the --

THE COURT: Who are the directors?

THE WITNESS: Who are?

THE COURT: Yes.

THE WITNESS: Well, the chairman of the board is Dr. Lubell. He is the Commissioner of Health. Oh, I know, other members include, besides the five appointed members, they include the Commissioner of Mental Health and Retardation Services, June Christmas; included also is

the director of the corporation, Dr. John Holloman. I am not familiar with current membership. The people are mostly prominent people. The president of HIP is a member of the board. There is generally a union official who is a member of the board.

THE COURT: All right. We won't pursue that any further.

Go ahead, Mr. Dunn.

BY MR. DUNN:

Q Inviting your attention, Doctor, to the package insert that you were referring to on direct examination, do you have any knowledge as to how the Food and Drug Administration prepares package inserts or revises package inserts?

A No, I don't.

Q Do you know whether the Food and Drug Administration evaluates reports received from the National Academy of Sciences, the National Research Council, Drug Efficacy Study Group, on a drug prior to revising the package insert?

A I know that they use those sources of information in determining whether or not to approve a drug, but I really don't know anything about the process involved in development of a package insert. I am not sure if that is

plugged into the same informational channels that the processes involved in making a determination whether or not to license or allow a drug to be manufactured and dispensed. I really don't know what is involved in the packaging insert.

Q A drug which may cause deterioration of bone marrow -- well, what was the drug?

A It is a drug called -- the generic name is chloramphenicol and the brand name is Chloromycetin.

Q Doesn't in that instance the adverse reaction or the possible side effect of deterioration of bone mawrow, isn't that described as extremely rare?

A For that drug it's rare, but it occurs --

Q It is on the package insert, is it not?

A I haven't seen the package insert. I don't remember the package insert for that drug. But the point I was making --

Q No, I am asking, you testified that --

THE COURT: You just ask your questions, Mr. Dunn. The witness will answer them. What is your next question?

MR. DUNN: Yes, your Honor.

Q The package insert that you were describing is the advice given to the physician to warn the patient

or caution the patient about this side effect?

A I believe it is.

Q About the deteriorative bone marrow?

A You mean with Chloromycetin?

Q Chloromycetin, yes.

A I am not familiar with the package insert for Chloromycetin. I haven't looked at it for at least ten years.

Q You described the package insert, I believe, Doctor, as in effect a disclaimer by a drug manufacturer or, as I understood it, and correct me, please if I am wrong, an attempt on the part of the drug manufacturer to protect itself against liability because of possible side effects, regardless of how remote these effects may be. Is that essentially what you said, Doctor?

A I am not sure it is just medicolegal liability that is involved. I think they are also concerned that a side effect might appear in the clinical use of the drug that they had not predicted. And even though they were supposed to have done thoroughgoing studies in animals and toxicity studies in small numbers of humans, that sometimes drug companies have been made very uncomfortable by the discovery after wide clinical use of the drug of a side effect or an adverse reaction which the company had not

discovered during its early studies. That is not, of course, unusual. That is in the nature of the development of drugs.

But my impression is that they include every adverse reaction which theoretically could occur and frequently include adverse reactions which no physician would consider likely with that particular drug, in order to cover the possiblity of its in fact later on appearing as a genuine adverse reaction to that drug. I think then they could point back and say, "Well, we predicted this."

I think the point I was making is that there is such a deluge of unverified information in that package insert that bears no genuine relationship to real side effects that one sees in clinical practice that the package insert is of no clinical value and in fact is misleading if taken literally.

Q You say this notwithstanding the fact you are not conversant with the way the Food and Drug Administration prepares the insert?

A I am conversant with the way practicing physicians use inserts, and that is what I am speaking of.

Q I draw your attention to the package insert on Dolophine Hydrochloride, the latest one, and invite ysour attention to contraindications, and then followed by Warnings,

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starting with the Drug Dependence.

A Right.

Q Would some of these Warnings, if true, be more serious than other warnings? Would some of the effects be of a more serious nature?

A You are talking about this particular insert or inserts in genera?

Q This particular insert.

A This particular insert, yes, the warning varying in how relevant they are.

Q Could some be more predictable than others in possibly occurring?

A Yes.

Q Is it significant to you that there is only one warning and that is the one, "Use in Ambulatory Patients," which includes the statement that the patient should be cautioned accordingly? Is this of any significance to you, Doctor, as a practicing physician?

A No. What it means is that all of the other cautions are for the physician's information. For example, when it talks about the management of --

THE COURT: You don't need to give us examples.

A I am saying, that is something that you have to tell the patient, while the other thing is something

the doctor has to know in his clinical management.

THE COURT: Mr. Dunn, anything else?

MR. DUNN: If I may just have a moment. There may be something.

Q Would you not be concerned about this: As a physician at the present time, mindful of the controversy that surrounds medical practice at least with respect to malpractice insurance, would you not be concerned if, as you understood it, a drug company prepared and had a package insert approved by the Food and Drug Administration which contained a warning and advised the physician to warn or caution the patient about this possible side effect, would you not as a prudent physician feel constrained to so warn the patient? The same as you described the manufacturer as being cautious enough to protect himself from a possible products liability case, would you not be concerned about a malpractice case?

A Now, if I used this -- this insert is -- if I used inserts as a guide to clinical practice, it would be much more difficult for me to be a good physician. For example, there are certain side effects of drugs -- I am not talking about the drugs that we are discussing -- there are side effects of certain drugs which patients should not be warned about. Because if you warn them about it, they are

going to get it, and if you don't warn them about it, they won't get it, but which you have to keep in mind as a physician. So that if the patient comes in and says, "I am experiencing so-and-so," then you discuss it with him and decide whether to change the dose.

So there are lots of side effects that I would not warn the patient about, even if so directed by the manufacturer, because the clinical value --

Q But the manufacturer ordinarily does not advise or caution the patient --

THE COURT: Your point is one thing, but let us just ask questions and not argue with the witness, please.

Q Would the manufacturer ordinarily admonish you to warn the patient or caution the patient against the side effect of dryness of the mouth?

A I don't know. I don't know what manufacturers ordinarily do with package inserts, because I haven't had a large experience recently with package inserts. I don't know if I can answer that. But all I can say is, I would make a judgment about the particular comment. And there are things I would warn patients about that I don't even mention in the package insert. Because they bear so little, in general so little genuine relevance to the clinical practice in terms of real adverse reactions, that I would be

damn sure I was familiar with the medical literature on the subject and use that as the basis for making my clinical judgments and for the basis of determining what to warn patients about and what not to warn them about.

In terms of malpractice, I think --

THE COURT: I think you have covered it.

MR. DUNN: I have no further questions, your Honor.

THE COURT: Any redirect?

MR. BALBER: No redirect, your Honor.

THE COURT: Thank you very much.

(Witness excused)

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UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

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CARL A. BEAZER, et al., :

Plaintiffs, :

-against- : 72 Civ. 5307

NEW YORK CITY TRANSIT AUTHORITY, :

Defendant. :

----------x

January 13, 1977
9:30 a.m.

BEFORE:

HON. THOMAS P. GRIESA,

District Judge.

A P P E A R A N C E :

ELIZABETH DuBOIS, ESQ.,
ERIC D. BALBER, ESQ.,
MARK MORRILL, ESQ.,
Attorneys for plaintiffs

EDWARD W. SUMMERS, ESQ.,
GILBERT T. DUNN, ESQ.,
Attorneys for defendant

* * *

NATHANIEL WRIGHT, called as a witness after having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. BALBER:

MR. BALBER: I would just like to note that the record indicates that Mr. Wright started working for the Transit Authority --

THE COURT: I have that.

MR. BALBER: Okay.

Q Mr. Wright, when did you use heroin for the first time?

THE COURT: That's also in the record, isn't it?

MR. BALBER: Your Honor, he gave a date at his disciplinary hearing, but Mr. Wright tells me now that was not the correct date.

THE COURT: Let's have the correct date.

Q When did you use heroin for the first time?

A In 1972.

Q At your disciplinary hearing you said 1965. You said about 1965.

A I did.

Q Why did you give that answer at that time?

A Well, during the time I was being examined, I was afraid, nervous, they were coming at me sort of fast and that was the first thing into my mind was that date, but after I read the transcript and discovered that it was no way that that could be possible, then I brought it to your attention.

Q So you began using heroin then about two years after you began working for the Transit Authority?

A That's correct.

Q Before 1972, had you ever used heroin or any other illicit drugs?

A I had not.

Q When you first started using heroin in 1972, how often did you use it?

A About four times a week.

Q At what point did you begin to use it daily?

A Six months later.

Q Mr. Wright, the record shows that you went into methadone treatment in January of 1974. That was about

18 months or so after the period of time youbegan to use heroin daily.

Was there at any time before January 1974 that you thought about doing something to rid yourself or your addiction?

A Yes. Immediately after I discovered I was addicted to drugs.

Q When was that, that was -- when you started using heroin daily?

A That's correct.

Q Did you think at that time that you might tell your T.A. supervisor that you were an addict and ask for his help in getting treatment?

A Yes, I thought of it.

Q Did you ask him?

A No, because I knew that there was no policy to protect me.

Q How did you know that?

A There were rumors about people that I found out that was on drugs and they were terminated when it was discovered.

MR. DUNN: I can't hear the witness.

THE COURT: Speak up a little bit.

A Well, there were rumors of people who was

addicted to drugs or who have used drugs that they terminated. So I knew from that that there was no policy to protect drug users.

Q Did you know anything about the Transit Authority's policy about drug rehabilitation programs?

A No, there was no policy for rehabilitating -- to rehabilitate people who were on drugs.

Q At that time in 1972, when you first thought about getting off heroin, did you try to do something to help yourself without a treatment program?

A Well, I tried to detox myself cold turkey or whatever you want to call it to no avail.

Q In other words, you just tried to abstain from drugs?

A That's right.

Q What happened?

A It was too hard, I couldn't do it on my own, so I seeked help.

Q Did you apply immediately for admission to a treatment program?

A I wanted to, but I was afraid to because of the fact, I found out that there was a methadone program, but it was state and I didn't want, you know, to trace that back or the Transit Authority to get the information.

Q How did you think the Transit Authority would get information from the treatment program?

A I thought the clinic would notify the Transit system so I didn't go at that point, but it was getting out of hand really.

Q Did you take any steps to deal with those fears of discovery when you finally did enter treatment in January -- you finally did enter treatment in January of 1974, correct?

A I did.

Q At that time did you take any steps to deal with those fears you just described?

A Yes, I did.

Q What did you do?

A I entered the program, I changed my identification because I didn't want it to get back to the Transit Authority.

Q How did you change your identity?

A My name was Nathaniel Wright. I went in Nat Wright. I changed my Social Security. I told them I wasn't employed figuring there was no way they could trace it.

Q Mr. Wright, in just one sentence or two sentences, what were your duties as a car maintainer?

MR. DUNN: I object, your Honor.

THE COURT: I was going to ask that anyway. I don't know what the designation means.

Would you answer, Mr. Wright?

A I was a painter painting exterior and interior of subway cars as a car maintainer.

Q You also worked as a structural maintainer?

A That's correct.

Q What did you do as a structural maintainer?

A Painting the structures, pillars in subway stations.

Q Buildings?

A Yes, the structure of a building inside, interior.

Q Did you have anything to do with the movement of trains or passengers?

A No, sir.

Q If you had not performed your duties properly would you have endangered your co-workers?

MR. DUNN: Objection, your Honor.

THE COURT: Well, I will allow it. I don't think it is particularly helpful.

A No, sir.

Q What would have happened?

A Well --

MR. DUNN: Objection.

THE COURT: Really, there is no contention here that the Transit Authority is constitutionally prohibited from having a rule against heroin addicts working.

Now, to argue that they wouldn't have, while addicted to heroin, they would not have endangered somebody just is completely out of the question. It's not part of the case.

MR. BALBER: No, your Honor --

THE COURT: I think it is a waste of time and I will sustain the objection.

MR. BALBER: Your Honor, the only reason that we tried to bring it out was because at our last hearing I believe you indicated quite clearly that you thought that one of the very strong arguments in favor of the Transit Authority taking a severe policy against Mr. Beazer and similar persons was that they endangered lives.

THE COURT: I said I thought there was no way Icould constitutionally say that the Transit Authority had to keep in employ people who were heroin addicts or could not discipline them for violating that rule.

You are just departing from the realm of reality to introduce testimony that while addicted to heroin they would not have endangered people. The man's opinion as

to whether he would have endangered or not is totally beside the point.

The Transit Authority can have that rule barring heroin addicts from employment. That isn't an issue in the case.

Do you have any other questions?

MR. BALBER: No, your Honor, we are finished with Mr. Wright's testimony.

THE COURT: Any cross examination?

MR. DUNN: No cross examination.

THE COURT: Mr. Wright, you may step down. Thank you.

(Witness excused.)

what. different standard than what is laid out in cases. The statute talks about someone intentionally discriminating. I must confess I am puzzled about the back-pay problem.

I must say to you that, in my own sense of what is fair and right here, I wouldn't award back pay because I believe that this is not like the case of discrimination against blacks, where the obviousness of the vice has been apparent for so long.

I think this is a case where the questions involved were very controversial and there was a hard-fought trial. There would be hard-fought appeals, I am sure. And I just think to say Transit Authority has to go back before the Court's decree and give a lot of people back pay does not strike me as fair.

I state frankly to you I don't really know if that is a proper application of discretion or not.

MR. BALBER: I know you are not fond of extensive briefing, but if you like I will submit additional memoranda on this.

THE COURT: I think we have lots of memos on this. Isn't your appeal up there now? What is the status of your appeal?

MR. BALBER: The appeal is in the Second Circuit and the brief schedule has been set already by the

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completion of his methadone doses. Diaz was again examined at Beth Israel on July 27, 1976. At that time there was no evidence whatever of drug usage.

This is another case like the case of Frazier where we have clear evidence of a man who has licked the heroin habit and has indeed successfully gone through a methadone program and completed it.

At the present time there is no evidence whatever that he is taking any illicit drugs or even taking any methadone. Nevertheless, the Transit Authority in its July 19, 1976 report concludes that Diaz is not employable.

The report states that he is unemployable not only because of his narcotic history but under what the Transit Authority says are its general standards regarding suitability for Transit employment.

I can only conclude that the statement about Diaz' not complying with the Transit Authority's general standards is not made in good faith. There is no evidence whatever that Diaz lacks the incentive to work, lacks work habits, lacks the work skills required for sheetmetal work of the kind he applied for back in 1970.

The Transit Authority mentions a criminal

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As far as Diaz and Frazier, it is a closer question, but I am really inclined to think that the sounder thing to do is to have a little patience and see what the Court of Appeals does.

It doesn't make a lot of sense to me to install people in employment in the Transit Authority and work out the seniority rights, have them start work, and then have them be yanked out.

This is not an easy case and it won't be an easy appeal. It is a controversial subject and the outcome in the higher courts I think nobody can predict with confidence.

The Court of Appeals may take a different view or they may take the same view, but it is going to be a case where there is a real contest in the Court of Appeals.

MS. DuBOIS: Your Honor, on those two people, if in your mind it hinges significantly on what happens in the Court of Appeals, can't we leave that issue to the Court of Appeals and let it decide whether there is a strong likelihood of reversal?

THE COURT: I think that is unfair. The determination should be made in the District Court about whether there is a stay. I am vastly more familiar with

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

----------X

CARL A. BEAZER, JOSE R. REYES & FRANCISCO DIAZ, INDIVIDUALLY & ON BEHALF OF ALL OTHERS SIMILARLY SITUATED,

Plaintiffs,

-against-

N.Y.C. TRANSIT AUTHORITY, ET AL.

Defendants.

----------X

Examination before trial of N.Y.C. Transit Authority by Dr. Louis Lanzetta, taken by the Plaintiffs, Pursuant to Notice, held at the Legal Action Center, 271 Madison Avenue, New York, on March 8, 1974 at 9:45 o'clock a.m., before a Notary Public of the State of New York.

* * * * *

Q Did you specialize during your internship or did you do a residency?

A No, I had a rotating internship.

Q Did you do a residency?

A No.

Q Have you published any articles or books?

A No.

Q Could you describe to us your function at the Transit Authority, what generally your duties and responsibilities are?

A At the present time?

Q At the present time.

A Well, one of my functions would be to see that the policies of the Transit Authority as far as

the Medical Department is concerned are carried out.

I am in charge of all medical personnel which I think I have 19 physicians working for me. I also have other professionals, the nurses, laboratory technicians.

Then, I am also involved in making decisions. In many cases, in psychiatric cases I don't make the decisions, I make the decision whether the individual should be, say for instance referred to a psychiatrist. I do make decisions in narcotic cases because of my experience. I also, well, any of the functions that is demanded from me from the executive office.

Q Do you approve all referals to consultants?

A Do I approve?

Q Yes.

A Well, personally, let's see on all narcotics I approve. On al

In cases where the report is such that we may suspect that he may be using drugs, again what we do there, he has a physical is given, a urine is taken and occasionally they will call me in to see the individual.

If there is an obvious thing where the clinic physician feels the man should be taken immediately off the job for example, the other day I was called in because there was a perforated septum. Although the man denied taking any drugs, I felt that was enough for me to take him off the job temporarily until we got the urine report. If the clinic physician finds track marks on his forearm he will call me in and I may take him off the job pending the urine examination, a temporary thing.

If the clinic physician does not find any physical findings but except that the report is such that they feel the Department may feel by his behavior that he may be using drugs then I don't do anything about it until we get our lab report.

Now, and of course if I get a positive urine then I am the one that makes the final decision or I may ask for a consultation depending on how I feel about it. I mean the question of what I find.

Q Could you describe under what circumstances you do ask for a consultation?

A I would ask for a consultation, well say, when I would not ask for a consultation all right? If I find morphine in the urine, if I found amphetamines in the urine, if I find nembutol in the urine, if I found any drugs in the urine.

For instance, if I found quinine, on several occasions, first of all, I wouldn't on the first time, because I would have to ask, do you drink gin and tonic, do you use any mixtures and so forth and if he does, fine that is all right. Then we have the individual sign a statement to the effect that he will not use quinine as a beverage or any quinine products known to him for say a period of six months.

Now, during this time we will call him in without notification and take a urine on him.

Now, if I find two or three urines on him of course we have to go back again, in other words,

I don't have any definite physical findings when I found quinine, but if I find track marks I will immediately come to a conclusion, but I also will send him to Dr. Trigg for his opinion. If I don't find anything definite, say for instance the man is a snorter, and I am not certain because he does have an erythematous nose or a small ulceration, well, that is not enough, but now, he comes in after he has signed a statement that he hasn't used any quinine products and we find quinine in the urine, on two or three other occasions, I usually wait, you know, then I send him to Dr. Trigg and explaining to him what exactly went on, that the first time the man said he drank gin and tonic and of course at this time he has signed a statement to the effect that he wouldn't use any products containing quinine of his knowledge and that I physically find it, the other physical findings, if there is an erythema of the nose or some small ulceration, then I ask for his opinion and I make an appointment and I send him to him.

Now, even though Dr. Trigg may feel that the man is not a drug user, I may still continue

to follow this individual.

Q Is the only circumstance under which you refer a person to Dr. Trigg, if you find quinine in the urine with no other symptoms?

A When I find just quinine in the urine and say I find no pathognomonic signs, now if he has track marks over his arms, I am not going -- well, I will have to send him to Dr. Trigg because it has been set up so, that I would send him to Trigg but I would still have my own opinion.

Q I didn't understand what you mean by your phrase, "It's been set up so"?

A Well, I think it is a question of the union and the Transit Authority.

Q I see.

A Where unless we actually find the drug in the urine we should have a consultation.

Q Unless you actually find morphine in the urine?

A Morphine or amphetamines or barbituates or qualode or any of the control drugs.

Q Is it a written statement of that consultation?

A Oh, yes.

Q I see.

A You mean a written report by Dr. Trigg?

Q Yes.

A He sends me a written report, definitely. Many times the statement is, he can't explain why the quinine but he doesn't feel the man is a user of drugs. So the fact that he said he can't explain it, so I continue following this individual. He does say that the nose may be erythematous but that didn't prove anything. He wants to be absolutely certain. In those cases I don't send him to him because I am absolutely certain because I can find the drug in the urine.

Q What weight is given to Dr. Trigg's report?

A Complete, if Dr. Trigg states that the man in his opinion, the man is not using drugs, then I do not take him off the job. I do not take him off the job but I do follow him, in fact, Dr. Trigg in many cases says he should be kept under observation, you know, because Dr. Trigg himself may feel he is not certain, but he has no reason for it because I think unless Dr. Trigg finds definite track marks I believe or perforation of

the nose I guess he doesn't want to say the man is a drug user.

Q If Dr. Trigg said that a person is definitely not a drug user, do you then drop all following all surveillance of that individual?

A He has never said definitely.

Q He has never said definitely either way or never said that somebody is definitely not a drug user?

A He never said definitely, he says it is my opinion that he is not a drug user but he has said on cases that this man should be followed or he should be kept under observation.

Q Does he on occasion say that in my opinion this individual is not a drug user and no more than that?

A No, he goes through the whole thing, he tells me about his examination and all this is his conclusions I am talking about.

Q If Dr. Trigg says that in his opinion a person is not a drug user and does not indicate that the person should be placed under observation, do you?

A It is just an opinion now, he didn't say

definitely. It is just an opinion because he will state I cannot explain the reason for the quinine in his urine, So that he is puzzled as much as I am puzzled.

Q Do you have any written statement of this agreement you referred to between the Union and the Transit Authority?

A No, no, I shouldn't make that statement because the reason why I shouldn't make that statement, because I don't know whether it is an agreement or not. I will say that, which is an open record, that I have been at Dr. Trigg's office on a number of occasions and Dr. Gallant where I have discussed drugs, now, we have had a conference with both the Transit Authority officials and the Union officials, but as far as I say of anything going on, I don't know, I wouldn't know. I was just told that they felt I should get a consultation unless I actually found the drug in the urine.

... opinion.

Q You referred to a number of meetings at Dr. Trigg's office with the Union and the Transit Authority?

A Just one, I have had a number of meetings with him, I mean to discuss drugs, you know, in fact, our last meeting was discussing qualode with him because that was the new drug that was being used.

... the street.

Q For a minute, on that meeting, that one meeting with the Union and the Transit Authority at Dr. Trigg's office, when was that meeting at his office?

A This was a few years ago, I think.

Q Do you remember who was present?

A Yes, surely I remember who was present. I was present, Mr. McClaren was present, Dr. Trigg, Dr. Gallant I believe was present. I think Mr. Van Riper was present. I am almost sure that Mr. Van Riper was present and Sedar was present, who is one of the -- I think he has been assigned by the Union on these drug cases. Now, I am not certain whether Dr. Marillo who is from MABSTOA was present, I mean this, I am not certain I think he was, I don't think anybody else was present.

Q You think he is a good doctor?

A A darn good doctor, I think the world of him.

Q Dr. Lanzetta you referred to several types of medical examinations that are done by your

department. I would like to go through all of them actually, starting with the pre-employment exam. When applicants are examined, do they have to get to a certain point in the application process before they are given an exam or is that the first thing that is done?

A First they have to pass their examination for that job, then they have to be certified, then they are referred to our personnel. Then they are referred to the medical department for their examination. Now, we have certain medical standards for pre-employment and we follow those medical standards

A (Continued) Well, we have a pre-employment physician, that is all he does, is examine patients and he is supposed to know or he does know or at least he is the administrator there that knows what

medical requirements are for qualifications. He is permitted to disqualify when it is an absolute certainty.

ne will be referred to
If it is an administrative problem or a narcotics, question of narcotics he is referred to me

Q Could you describe to me in detail the physical examination that Dr. Ziewicki and now Dr. Letterisi would perform on job applicants?

Then also

the C. ... Now, every

pre-employment below the age of 35 we do a special urine on them except when there is suspicion of possible drug use, then we take a urine on any individual, but all below the age of 35 we take a urine.

e, they are supposed to check for track marks, a lot of them miss. They are supposed to check for track marks, ...

...and past history.

Q Dr. Lanzetta, what type of report do

you get back from the laboratory that does the urine analysis?

A What type of report?

Q Individual written reports on each applicant?

A Yes.

Q Whether negative or positive?

A Yes, right.

Q Who are those sent to?

A They are sent to the medical director's office, which is my office.

Q Are they then appended to each application, the results?

A Yes,well if they are negative I mean it is not brought to my attention but if the urine is positive then the application or the physical examination is brought into me with the report and then I call in the applicant you know, if it is positive I call in the applicant for further questioning or discussion.

Q If it is positive, what do you mean by positive; first of all could that include the presence of quinine in the urine?

A No, no, if he has just quinine in the urine

and he tells me he drinks gin and tonic I take his word for it but again I will follow that man. I will give him the job if I find no physical findings; but if I find track marks or if I find a perforated septum and he can't explain it, then it is a different story.

Q Do you ever send applicants to Dr. Trigg for consultation?

A Not applicants, no.

Q Not at all?

A No, that I make the decision on. I don't believe any applicant has been sent.

Q But you say if somebody has Quinine in the urine then you would allow him to pass, you would have an unqualified task?

A If I find no physical findings?

Q Right.

A But I will still check on this individual. I will tell him he is getting his job, I will have him sign that paper to the effect that he is not going to use any Quinine products. Now, he becomes an employee, now if I find Quinine in the urine I may send him to Dr. Trigg.

Q Could you describe to me the periodic

examinations?

A Well again the periodic examination would be almost the same as the pre-employment, it is the same type, the doctor asks him since his last periodic because a motorman, a bus operator has periodic examinations if they are over 50, it is every year. If they are below 50 it is every two years so that the doctor will say he will have his last periodic there, he will sak him since your last periodic have you had any surgery, and that will be added to the past history and then examine the man the same way as you would examine the individual in the pre-employment. If I find something wrong, let's say for example, the pressure is a little high, the heart doesn't sound properly, then of course he's referred to our internist, we also take a urine. Again on all people below the age of 35 or in suspicious cases.

Q Dr. Lanzetta are you responsible for the formulation of medical standards for the Transit Authority employment?

A No, but I am consulted.

Q Who is responsible for those standards?

A I think the executive officers are responsible,

as far as Mr. McClaren, as far as my immediate supervisor I consult with him, with who he consults with I don't know.

Q Where do you get these standards from, do you get them from Mr, McClaren?

A Those are the policies that are the standards, they have been sent down to the Civil Service Commission. They were approved by the Civil Service Commission, that is all I can say to you, those are the medical standards for employment.

Q Do you know who writes the actual written papers on that?

A I wrote the actual standards that were submitted to the Commission, Mr. McClaren definitely must have approved it, but I was the one that made up the medical standards, of course it was sent to Mr McClaren for his approval.

Q Dr. Lanzetta I would like to show you appendix D-2 to the answer of the City Defendants to Plaintiff's Interrogatories in this case. This is entitled, "Medical Standards for Citywide Titles."

A We are not talking about Citywide Titles.

Q "Used in the New York City Transit Authority," I would like to show you this document and ask you if you are familiar with this set of standards?

A They seem to coincide with our standards.

Q I would like to refer you to specifically to number 6 on that list which says in substance that a history of drug use --

A Well, this is wrong, we don't have that.

Q Let me complete the question. It says, "That a history of drug use may reject unless the eligible is shown to be successfully participating in a recognized chromotheraputic program or satisfactorily successfully completed any other acceptable program and is drug free." Is that an accurate statement?

A We do not have that in our standards.

Q You do not?

A No.

Q Who changed that policy at the Transit Authority?

A We didn't change it, we didn't have these standards. I had my own, we had our own standards at the Transit Authority.

Q For Citywide Titles, well, you only have one set of standards?

A We only have our standards for the Transit Authority. If the standards for the Transit Authority you know, well go ahead you question me, I mean I am not going to question you.

Q Dr. Lanzetta on the pre-employment physical do you examine everybody whoever goes to work for the Transit Authority?

A Yes, who is going to work for the Transit Authority.

Q That would include stenographers and so forth?

A That is correct.

Q You do examine stenographers and secretaries?

A That is correct.

Q Does anybody examine them?

A Do I; the ones who do pre-employment examine them.

Q Your pre-employment department does examine stenographers?

A People who are hired by the Transit Authority are examined by our physicians and we go by our medical standards.

Q Nobody else examines those people, let's take for example stenographers, no other city agency does a medical exam?

A I don't know.

Q But you don't know of any other medical report other than what you perform?

A No I don't.

Q Are you aware of that policy that I showed

you being implemented in other city agencies?

A Yes.

Q Are you aware of the fact of that being implemented by mayoral directive?

A Not on the Transit Authority.

Q In other city agencies?

A I have read about it, yes.

Q Did you ever consider that policy for use in the Transit Authority?

A No, we have a certain policy and I have stuck by that one policy because I believe in that policy.

Q Could you describe that policy to me Doctor, the policy of the Transit Authority with regard to people and drugs?

A The use of any narcotic drugs disqualified any individual which includes Methadone.

Q What about past use, people who have previously used drugs and are now drug free and have been for some time?

A Who is to tell me how long they have been drug free. I have people, they come in they have track marks they tell me I haven't used drugs for five years and I know those track marks are less than

five years old, who is to tell me.

Q What if somebody comes in without track marks and tells you that he used drugs ten years ago?

A Without track marks?

Q Without track marks.

A Why would he tell me that?

Q Suppose he did.

A Well, now a person who would say that, then I would send him to a psychiatrist.

Q What?

A I really mean it, I would send him to a psychiatrist if the man said I used drugs ten years ago and he has no evidence, I would want to know why this man is saying this.

Q What if you found it in somebody's hospital records that they had used drugs 10 years ago but you found no other physical symptoms?

A I would have to find physical signs if he had used drugs.

Q What type of physical signs would you find if somebody had used drugs ten years ago?

A I would find track marks there for the rest of their life.

Q What if they had not injected drugs, what if they had snorted drugs?

A Snorted drugs, if they snorted for any length of time I would find that they have a perforated septum.

Q Ten years later you would find that?

A Oh yes that would never heal.

Q What if somebody had used drugs for a very brief period of time and you found no physical symptoms but you did discover it in the hospital records?

A Now wait, are you talking about a drug that had been prescribed by a physician?

Q No, an illegal drug.

A I would not accept him.

Q Dr. Lanzetta I would like to show you appendix D-1 to the Answer of the City Defendants in this case to the Interrogatories of the Plaintiff and --

MR. DUNN: May we see that please, we haven't seen that yet.

BY MR. MORIL:

Q This is entitled, "Medical Standards for Tit'es in the Rapid Transit Railroad Service," I will show it to your attorney first.

(Mr. Dunn lookingat document.)

MR. SUMMERS: What is your question to the doctor with respect to this document?

MR. MORIL: I have a series of questions with respect to that document.

MR. SUMMERS: Do you want to know whether he recognizes it or has he seen it or what?

MR. MORIL: I am going to show it to him and ask him if he had seen it.

MR. DUNN: I am going to ask that anything that was appended to the City's Answer that we have not been furnished with a copy of, if you intend to enter that as an exhibit, we would like to havea Xerox copy of it.

MR. MORIL: I do intend to refer to it and I will be happy to furnish you with a Xerox copy.

MR. DUNN:No, we would like to have it before so we can follow your questions pertaining to it.

MR. MORIL: Can we have this

marked as Plaintiff's number 2 for identification, the document is entitled "Department of Personnel, City Civil Service Commission, Medical Standards and Regulations for all operations and maintenance positions, New York City Transit Authority."

(Whereupon, the above mentioned document was marked as Plaintiff's Exhibit number 2 for identification, as of this date.)

Q Dr. Lanzetta I am showing you this exhibit and I am furnishing at the same time a Xerox copy to your attorney. Are you familiar with this set of medical standards?

A Yes, this here definitely I am.

Q Is this the set of medical standards that you wrote?

A Myself, I mean let's say I wrote, say at my suggestion.

Q You suggested these?

A Right.

Q I refer you specifically to number 51 on this list which is on page 4 which describes your

analysis and says, "Presence of unauthorized or unexplained substances on examination rejects."

A That is correct.

Q What is an unauthorized or unexplained substance?

A Well, say blood in the urine would reject if you can't explain it, say Morphine in the urine where I asked the individual if he has taken Morphine or been prescribed by a physician, he can't explain it, he said he hasn't, let's say I find Barbiturates in the urine I want to know if he is taking medication and if he can't explain any substances that I find in the urine I am going to reject, that is the substances, whether they are due to a disease or whether they are controlled substances.

Q Are those the only unauthorized or unexplained substances, Morphine, or barbiturates?

A I would say blood, albumin, puss cells. I mean there are many things, diseases of the kidneys which would show in the urine and medications.

Q What about Methadone?

A Methadone, is a drug, definitely is a narcotic.

Q Who decides what is an unauthorized substance, do you?

A That is the policy of the Transit Authority, we have had that policy.

our

A I am the one that whenever there is an unexplained substance in the urine, I make all of those decisions.

laboratory

Q How did it come to pass that Methadone was put on the list of unauthorized substances?

A It didn't have to be put on the list, it is a narcotic, it is all narcotics, unexplained substances, it is using a narcotic.

Q Are people who are on a special diet under the supervision of a physician prescribes to them diet pills or which are amphetamines, are they allowed to work for the Transit Authority?

A Yes, first of all let's put it this way, I mean first of all it is prescribed by a physician, which means that the dosage is such that it is controlled. In other words, people that get it off of the street do not control the amount of

amphetamines taken in but let me say this, that when they do find amphetamines in the urine a man is called in, he is certainly taken off any job like a bus operator or a tower man or he is taken off, I call his doctor to check on the doctor and I let him realize that this man may lose his job if I feel that this man doesn't need the amphetamine; if he is overweight and that is this doctor's opinion although it may not be mine, that I can't argue with the doctor.

Usually I have found in two or three cases, because I followed them up that they have stopped using the amphetamines. They are taking it under the direction of a physician, so that if they got a 30 day dose; first of all I don't know if you do know it, amphetamine is in Schedule 2, it is actually registered, so that these people cannot go to one doctor and get a 30 day dose and then go to another one and get more, because that is all registered through the State Narcotics Bureau.

Q Are amphetamines on the list of unauthorized substances?

A Yes, they are.

Q If a person is taking amphetamines under

medical supervision and with a presctiption, then he is not automatically fired from the Transit Authority employment is that correct?

A If I feel after discussing with the doctor that it is absolutely necessary that he have amphetamines, and then they do something while he is taking them, it becomes involved.

Q What if that person is taking Methadone under medical supervision with a prescription and is reporting to a Methadone Clinic several times a week?

A I will not accept him.

Q Why is that?

A All right, this man was a heroin addict; being a heroin addict, we don't know why he became an addict, but he may have had a personality deficiency; he may be a compulsive individual; he may have a deficiency in character; he may have had a behavioral problem and certainly he was not a motivated individual.

Now, when you have that type of individual, if he was motivated and he was detoxified, there is no reason for him to go onto a crutch; then that man still has the deficiencies that we are talking about, the fact that he needs a crutch. Now, when do I know

when some stress or strain where risk becomes involved, where he will go back to heroin.

Q

a crutch.

Q Dr. Lanzetta, again to refer you to number 51 on page 4, it says, "The presence of unauthorized, unexplained substances on examination rejects," does that mean rejects automatically?

A That is correct.

Q That is absolute?

A Yes, that is absolute.

Q What if you found just track marks but nothing in the urine?

A You mean clean urine but track marks?

Q Yes.

A Well immediately I try to get the history from the individual and he has to admit it. Then he admits it, then I say, he will tell me, it is always over five years, I mean I have never heard one tell me that it has been less than five years, but anyway I check over the track marks and I notice the marks, that I know, I am quite certain that they are less than five years old, it may be six months

ago; then, who is to say that this person that has these track marks doesn't experiment with drugs occassionally. Don't forget, now you are talking about a narcotic, a man doesn't have to become an addict because he experiments with that, I had a man with a kidney stone who was taking Demoral and I took him off the job for two weeks, he said that didn't make me a drug addict.

Q But, confining ourselves to the pre-employment physical, if you find a track mark, does that person ever get a job, does anybody with a track mark ever get a job?

A It is a risk involved.

Q Just does he or does he not?

A No, he doesn't get it because there is a risk involved. I do not know when this man stopped using drugs.

Q What about with

Q What about in a periodic, you have never seen a track mark?

A Not that I recall, not that I recall, I have been called in and I said no, this is not a track mark.

Q What would you say and do if you found a track mark in a Transit Authority employee?

A You are asking me a supposition, aren't you?

Q Right.

A If I found him with a track mark, I want to know the reason for that track mark.

Q What if he told you he was a drug addict five or ten years ago?

A If he then admitted that he has used a drug then I don't know when he used it last and he is a risk as far as I am concerned because especially so in the periodics where there are bus drivers and motormen, I definitely do disqualify him if he used it.

Q It would be automatically terminated?

A Not automatically, I would mark him no work permanently.

Q No work of any type?

A Of any type.

Q Would you describe to me generally the process by which the policy of not hiring and not retaining in your employ ex-addicts was formulated, do you know when that policy was formulated?

A I couldn't tell you because it was there, I mean the thing is, you bring up a subject that I think no one was aware of drug addicts until lately,

I think maybe when I became medical director, and it was one of the standards you know, that drug addicts or barbituates or any dependent drugs, you would be disqualified.

Q Twenty-eight years ago you are saying this?

A No, I didn't say twenty-eight years, I said when I became medical director, twenty-eight years ago I worked in the clinic and I had no idea, and I think at that time we didn't have enough drug addicts to find them.

Q Was there a policy on Methadone when you became medical director?

A Again, you bring up the word Methadone, it is a narcotic and as long as narcotics disqualify, Methadone would disqualify, it wouldn't have to be named Methadone, it is a narcotic.

Q Did you ever talk to Dr. Densen-Gerber?

A I spoke to someone years ago, I went to a seminar on drugs and I think he was the head, he was the head doctor you are talking about?

Q Yes.

A No, this wasn't a doctor. The only people I have actually discussed drugs with, I mean a doctor that was supposed to be in that field I would say Dr. Gallant, I would say Dr. Trigg, I would say at the South Oaks Hospital where we had discussions, again if you were to ask me the name of these doctors who they were, I couldn't tell you and this is one where I discussed Methadone to quite an extent.

Q Did you discuss with any of these programs, the feasibility of consulting with them as to which of their participants might be good employees forthe Transit Authority; which of them were, did you ever discuss with them whether they had people who were stable enough to be Transit Authority employees?

A Well, they have always told me that they are stable, anyone at the end of a Methadone program has always stated that.

Q Have you visited any Methadone programs?

A Well, at Beth Israel, with Dr. Gallant and Dr. Trigg, I don't know if --

Q What did Dr. Gallant tell you about the Methadone patients, about the Methadone program?

A Well, he was assistant director of the Methadone program, so his reaction was that he felt that at the present time that was the only solution that they had and in comparing it to abstinence where he said abstinence, because at thattime I had discussed the Odyssey House with him and the Phoenix House and his reactions were, that he meant, did you ever see anyone come out of the Phoenix House, did you ever see anyone come out of the Odyssey House, but he felt that in the Methadone program at least a certain number of people could get out into society and do something.

Q I see, did he discuss with you the feasibility of some of these people working for the Transit Authority?

A No, I think Dr. Trigg was the only one, Dr. Trigg, usually it was he and I would discuss it. Dr. Trigg and I would discuss it.

Q What did Dr. Trigg say about it?

A Well Dr. Trigg felt that some of these people would be able to do some type of work.

Q I see, did youagree with him?

A No.

Q Did you ever talk to Dr. Dole?

A No, but I have read a great deal about him.

Q Do you agree that there should be an absolute bar to the employment of anybody with Methadone or with a drug history?

A I believe that if anyone should be employed in a Methadone program, they should be employed maybe in an area for example, in a small shop where that man is under constant observation and constant

supervision, but I certainly don't feel in an area like the Transit Authority where supervision isn't personal so that the risk factor is alleviated in these places.

Q What about in a position like a stenographer?

A Well again, again you are going into what I said before, if this individual was a person that was motivated, why is he on Methadone. I am taking the person as a whole when I am hiring the person.

Q Do you believe that anybody on Methadone, are there any people on Methadone who are motivated?

A How could they be motivated if they have to use Methadone, as a crutch.

Q Dr. Lanzetta, do you think that it would have an adverse affect on the public image of the Transit Authority if Methadone patients were in the employ of the Authority?

A Do you want my personal opinion?

Q Yes sir.

A I think it would, because I will tell you why, I mean I could picture headlines of something

where anything occurred, any incident, and it would be the fault of the man on Methadone, but the thing is, "Transit Authority hires drug addicts," that would be the headlines.

Q Do you think that was part of the reason for the policy?

A That was not my reason, you just asked me a question. This is outside, that is not my reason, I gave you my reason.

Q Is your reason that you don't feel Methadone patients are motivated?

A That is correct, that they are a risk.

Q Dr. Lanzetta, do you know of other Transit Authority that exclude people on Methadone or people who are drug free but formerly were drug addicts; do you know of any other Transit Authorities that have such a blanket exclusion?

A I don't know

Q Are you aware though as you stated earlier that I believe that other departments in the City do now implement that policy that I mentioned to you earlier, that is that they do hire people who are in a Methadone program?

A Yes.

Q Medical.

A No, not medical, they are disqualified as far as I am concerned if they are using Methadone.

Q I am sorry, I didn't make it clear enough. I am on another question now, are there types of physical ailments, I am not talking about drug use now, which disqualify people from certain types of Transit Authority employment, I am talking about diabetes or epilepsy?

A Yes.

Q How are these people terminated from Transit Authority employment?

A I didn't say terminated.

Q Thatis what I am talking about now?

A First of all these people are taking medication under supervision and direction, now remember that and their doses are so set. Now, these people have developed diseases that they didn't ask for, a drug addict, he becomes the drug addict, the diabetic didn't want to become a diabetic.

Q Do you believe that becoming a drug addict is a voluntary thing?

A I didn't say it was a voluntary process, I didn't say it was, it is voluntary because nobody is forcing them to become drug addicts, but you do know the reason, some of the reasons why people become drug addicts. As far as diabetics, I will disqualify him as far as pre-employment, but if he is working for us over two years, if it is less than two years and if he is in a position where it is hazardous he would be out.

Q Let's take for a moment Dr. Lanzetta, the case of a diabetic who has been working for the

Transit Authority as a motorman for over two years and on his periodic he shows sugar in his urine, what would then happen to him?

A First of all I would want to know the severity of the diabetes and have to bring in a glucose tolerance test. I would want a letter from his doctor and he definitely would be disqualified from running a train except if his diabetes was controlled by diet alone, and that a letter from his physician stating the fact that this employee's diabetes is controlled by diet, and he is taking no medication whatsoever, no medication whatsoever, now this diabetic is kept under constant observation.

Q Do you make any kind of investigation of the physician who wrote that letter to you?

A No, why should I, I mean the man has his registration number, I could look him up in the book if I want to.

Q But you accept the fact that he is a physician?

A I accept the fact that he is a physician.

Q Assuming for a moment now, that a diabetic's problem is not controlled by diet that he is taking insulin or something like that.

A Then he will have to be placed in a position away from hazardous areas, some form of restricted duty. If he has been with the Transit Authority over two years otherwise he is terminated.

Q Do you personally make that decision whether a person should be retained in his position or must be terminated?

A No, our internist, he knows the rules and regulations, that is why I am only quoting the rules and regulations, but our internist makes all of these decisions, but I know the decisions because I have to read, because I may disagree with him.

Q What type of position can such a person be placed in?

A He can be a railroad clerk.

Q What other positions?

A WEll, say for example, a conductor of a platform.

Q Could he be a bus cleaner?

A Car cleaner, no tracks, if he is taking insulin I wouldn't want him to go on track.

Q I see, could he be a change booth operator?

A I said railroad clerk, that is the same thing.

Q Do you have a list of these limited service positions, or do you decide by individual case or do you have a certain category of jobs that all people with a problem would go into?

A It would depend on the department where they could fit him, we only put the restrictions down but we don't tell the department where to place him, now we say this man should not operate a train, it should be off tracks, off structures, then the department will place him. They may havea place as a flag man in the street or something of that sort, they will place him, we just place the restrictions and then the department fits him in.

Q I see, are people ever terminated from employment because there is no position for them?

A Not if they are there over two years.

Q Dr. Lanzetta on both the periodic and the pre-employment physicals, do you meet the people who are rejected or in whom drug use is found ordinarily?

A On periodics?

Q Yes.

A We have had a couple of them.

Q Do you meet them personally, do you interview them?

A Yes, I interview them, oh, yes.

Q Can you give me an eyeball estimate of the racial composition of that group, are most of them black and hispanic people?

A Well, when you say most, I mean, what percentage are you talking about?

Q A very rough percentage.

A Well, say, I would say seventy-five to eighty percent would be a combination of black and Puerto Rican, now, this is a rough estimate, I mean after all it is not fair, we have these statistics, I think, because we keep a close statistics on all things. I haven't looked at them, I don't know but I know by the interviews that I have had.

Q But you do keep racial statistics?

A Yes, they do, I don't know, now that you bring this up, I don't know if we keep statistics on color or race, I think we were told not to, I am not sure.

Q Did you at one time?

A No, I don't think we ever did. You see, I am, you see this is my administration you see, they take care of that. In other words, if I disqualify a man let's say for morphine in the urine he goes out to the desk and there is an individual that takes care of all of these drug cases so that we have mostly reports, you know and then every three months or every six months according to the title, age and so forth. Of course I glance at the report, I usually glance at the averages of the pre-employment

that will be disqualified, the periodics, the names of those that have been disqualified, the referrals that have been disqualified, I just glance, I don't really study the figures. I would say, I am almost positive they didn't keep it on color.

MR. SUMMERS: May I remind the doctor that if he doesn't know something just simply say that he doesn't know the answer.

THE WITNESS: All right.

MS. DuBOIS: We asked this on the discovery, we asked for that on the discovery.

MR. DUNN: Well, the witness has answered that he doesn't know whether such statistics are maintained.

MS. DuBOIS: Can we clarify that with the witness, he thought maybe they were kept.

THE WITNESS: I said I am not sure.

MS. DuBOIS: I realize that, but do you know who would be sure so we can find out whether

these are kept or not?

MR. SUMMERS: As far as I know, they keep statistics but what the contents of the report is I am not certain, I can't tell you specifically if they do keep count or not of the people who are rejected.

MS: DuBOIS: All I am asking, since we asked for this on the discovery can you find out that information?

MR. SUMMERS: Anything you asked for on discovery you got.

MS: DuBOIS: Are you saying they positively do not keep this?

THE WITNESS: I can't say positively.

MS: DuBOIS: You can find out, if we asked for this in the discovery whether or not it is kept?

MR. SUMMERS: What are you asking?

MS: DuBOIS: The racial statistics of those employees and also

those applicants who are disqualified on the basis of either drug history or methadone use.

MR. SUMMERS: Well, I am certain at this point that statistics are kept with respect to the number of rejected in either category but I can't say now whether or not that indicates the race of the person, I don't know.

MS. DuBOIS: What I am saying, since we asked for that back about a year ago, can you now find out for us and let us know whether we can get that information?

MR. SUMMERS: Of course there is no problem in getting that information we have filed reports.

MR. BALBER: We are talking about those narcotics statistics?

MR. SUMMERS: I don't think a statistic is available.

THE WITNESS: I don't know whether they do put in the color, I

don't know.

MR. MORIL: Will you check on that for us?

THE WITNESS: We can easily check on it you know.

MR. SUMMERS: I don't think they do but we will check on it.

THE WITNESS: I do know by title, age and marriage they do check.

BY MR. MORIL:

Q You said about seventy-five to eighty percent of the employees, you said it was rough, on the periodics it seemed who were picked up for drugs, seemed to be Black or Puerto Rican, would that be true on the pre-employment also?

A You know, it is so difficult, I see so many people, you know all day long it is not only drug addicts, I see psychiatric cases I may be mixed up with one, whether it is a psychiatric problem that was disqualified or whether it was a drug problem that was disqualified, but I would say the majority, all right, over fifty percent I would say was either Black or Puerto Rican that I would say for certain.

Q Dr. Lanzetta, do you examine employees

who have been involved in accidents?

A Yes.

Q All employees who are involved in any accident?

A That is, wait now --

Q I mean in Transit Authority accidents?

A Yes, in those cases, yes, what do you want to know.

Q Do you do a urine test at that time?

A We do both a blood and a urine test.

Q Have you ever found evidence of drug use in somebody involved in an accident?

A Not that I recall.

(Whereupon, at 12:30 o'clock p.m., Hearing was resumed.)

BY MR. MORIL:

Q Now, Dr. Lanzetta, going back for a moment to the personal background, you said you were in private practice for awhile?

A Yes.

Q When was that?

A For a number of years, for thirty some odd years, yes.

Q Would you describe that practice to me?

A It was a general practice, a general practice.

Q Where was it located?

A It was located at 312 East 116th Street in East Harlem.

Q What were the years of that practice?

A From the middle of 1934 to about three years ago or four years ago when I became medical director.

Q At the time that you were working for the Transit Authority it was a part time practice, is that correct?

A Yes, up to the time I became an Assistant Medical Director, it was part time, yes.

Q Did you treat addicts in that private practice?

A No, I didn't treat addicts but I did try to

help addicts, by either referring them at that time to Knickerbocker Hospital, that is even before the program and then there was one place where they detoxify them; and didyou say did I ever treat them in my practice, I never treated an addict, I just helped them.

Q Dr. Lanzetta, I would like to refer you once again to the City Wide titles, people who don't, whose positions don't exist in the Transit Authority but in other City agencies like stenographers and so forth, do you apply the Transit Authority medical standard to those people?

A I do.

Q You do not apply the standards that are written in Plaintiff's Exhibit 2 for identification, these are the standards you apply referring to Plaintiff's Exhibit 2 for identification that I am referring to?

A Now, wait a minute, are we talking about methadone?

Q No, I am talking about generally?

A No, I don't because we are lax, more lax, we would be more lax with a clerk, maybe he has a high blood pressure, maybe a little higher than normal, we would not normally accept for another position. Although diabetes, we may reject it, it doesn't reject but we would make an individual determination. If they had a very severe diabetes and the person, he or she is taking 80 units of

insulin, I would be worried of insulin shock, this is a gray area but we are vey lenient for example, with vision, with blood pressure, if they have a rheumatic heart, we hired them, all of those things we are lenient, the only thing is the methadone.

Q Methadone is an absolute policy?

A Or a drug addict.

Q Any kind of narcotic history or of drugs is an absolute policy?

A That is the policy.

A First of all the policy was there previously, the policy has been there right along and the question of adding methadone is just a question that it was a narcotic.

Q Dr. Lanzetta, correct me if I am wrong, I believe you stated that among the people you consulted about narcotics and a proper narcotics policy for the Transit Authority, were Dr. Gallant and Dr. Trigg?

A I didn't consult them as far as our policy.

Q You talked to them about drug use?

A I just discussed, we discussed the Methadone program, we discussed the abstinence program, that's all, I didn't tell them what their policy would be if he was in the TransitAuthority; nor did he ask.

Q Did you discuss these merits with any other people, that is all I want to know.

A Just Gallant and Trigg.

Q Dr. Lanzetta, what is the reason that the Transit Authority will retain in its employ people who become diabetics or people who are discovered to be epileptics?

MR. SUMMERS: I think you are getting repetitious on all of this.

A Well, I am first saying, these people are motivated people, they are working, they developed a disease, now these other people on Methadone I said they are not motivated, the fact that they have a crutch and this is a risk, that is my answer, that is my only answer.

about the seizures?

Q What type of position would you take a person off if he or she was an epileptic?

A Oh, any position, where first of all if they have been working there over two years.

Q Yes.

A We would only give the restrictions again, she

would or he would, they would have to be in a sheltered area away from moving parts. Now, the type of job say for instance a person is a mechanic, I would expect him to be given a bench job, sit on a bench, say he was a motorman or a conductor, I would expect him to be a railroad clerk, where I feel he is just in a booth and that is it, that if he did get a seizure there it would be in a booth.

Q You would expect the person to stay in the same department?

A All I do is put down the restrictions, I don't, it is up for the department to find a job for him or the union, let's put it that way.

Q But there are some jobs you know you don't want people in, you know what a tower man does, don't you?

A Oh definitely I know what he does.

Q Would you say that an epileptic could do that job?

A An epileptic, I would never send over there or a diabetic.

Q Would you then tell the department what the restrictions were or would you say this person should not be a towerman?

A I said in a sheltered area, he has to cross tracks to go to a tower, I mean they know, they understand what we mean when we state the restrictions, a sheltered area away from moving parts, certainly trains are going by, you have to go down from the tower onto the track, they know what we mean by either a bench job if he is a mechanic or if he was a motorman or a conductor he is going into a booth.

Q But you give general qualifications?

A I don't, I just give the restrictions. This is routine, we have been doing it for years, and sometimeswe check off the list.

Q There is a check off?

A Of three different things, railroad clerk, railroad caretaker, railroad watchman, so we will check off railroad clerk on an epileptic but that doesn't necessarily mean he is going to be made a railroad clerk.

plenty of them in there.

Q Could you list for me some of the restrictions you put on a diabetic?

A Yes, depending now, I just told you, let's say the diabetic is free, for instance no medication, his diet, diabetes controlled by diet alone, he can go to full time work as a motorman. If a motorman is taking oral medication, we permit them to do yard duty but not in passenger service, although

we know that with oral medication you don't go into shock nor do you go into coma but we are playing safe, so we have yard duty. Now, if he is taking, if he is a severe diabetic, if we feel he is severe, and usually with them you find other complications, you have to watch it, then it is up to the internist to decide what restrictions he wants on that individual depending upon the complications, certainly if he is taking insulin I certainly am not going to give him a conductor's platform job. I am going to suggest again in a sheltered area in a non-hazardous area and so forth. It all depends upon the internist making the decision on the diabetic but you know for two years he has to be free of any medication to be in passenger service, if he is taking an oral medication he is allowed to go into yard duty, switching but not in passenger service.

Q What is passenger service, you mean --

A To go out on the road, carry passengers in passenger service, take out a train on passenger service.

Q You mean driving a train?

A Well yes, a motorman he is not allowed to

run a train on passenger service.

Q What would happen if a diabetic failed to take his or her medicine on a particular day?

A First of all he is not in passenger service if he is taking medicine, he is not running a train on passenger service.

Q So that, if somebody did not take his diabetic medicine on a particular day that it would be of small consequence to the actual safety of the Transit Authority?

A If he is taking medication, if he is on medication, he is not permitted to take passengers out.

Q But assuming that he has another job?

A Oh, you are talking about a different job?

Q Well, I don't know what job you place them on?

A You have to tell me what job.

Q Tell me a job that you place a diabetic in?

A All right, say a man is a tower man and he is taking insulin, I wouldn't let him be a tower man.

Q Where would you let him be?

A I would put him in a booth, again you are asking me, I give the restrictions, I wouldn't let him cross tracks, I wouldn't let him go on structures, in a sheltered area.

Q What I want to know, did you know of any reason that he [McLaren] or other Transit Authority officials responsible for the continuation of the policy disqualifying methadone people have for that policy beyond what you have expressed?

A I can't read their minds what they felt, I only know what I told them.

Q I know that, but do you know, have they told you, of any other reasons that they have, do you know of any other reasons?

A We just discussed we just discussed it in general and we decided, understand, the policy had been there and it was just a question that Mr. McClaren wanted to know something about methadone, I said it is a narcotic that is all that was necessary.

Q There was no other reason he presented to you?

A That is an old policy.

Q There is no other reason that you know of that he presented or not?

MR. SUMMERS: He has answered the question.

Q Well, as I understand it, you said

there is no other reason that he presented to you or it was just a general discussion?

A He didn't present any reason to me, he just asked me about methadone although he had his own information because we had been to Dr. Trigg, we had been to Dr. Gallant, we had been to the Odyssey House, we had been to the other places. Mr. McClaren came along with me on all of these places so that he may have gotten his own impressions and may have agreed with me, I mean that is all I can say.

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

----------X

CARL A. BEAZER, JOSE R. REYES and FRANCISCO DIAZ, individually and on behalf of all others similarly situated,

Plaintiffs

-against-

NEW YORK CITY TRANSIT AUTHORITY, ET AL.

Defendants

----------X

Examination Before Trial of the New York City Transit Authority, a Defendant, by WILBUR McLAREN, taken by Plaintiff, pursuant to Notice dated December 18, 1973, held at the offices of the LEGAL ACTION CENTER, 271 Madison Avenue, New York, New York, on January 31, 1974, at 10:15 A.M., before a Notary Public of the State of New York.

Q You referred previously to some sort of a disciplinary citation. You mentioned a "caution" --

A Yes.

Q There is also citations called "warnings", is that correct?

A Warnings, cautions, reprimands.

Q Could you describe generally what the difference between those three are?

A Well, it's a question of the seriousness of the written -- of the matter. The reprimand is a formal written reprimand that goes into the record and as a result of a Trial Board -- the warning or caution has much less standing and it would be issued for instance for minor violations and so forth and it's not as a result of a trial or -- it could be, but it may not be. Maybe be that a person failed to sound his whistle go-

ing through a station or one thing or another. He could be given a caution for that. If it develops that he has a string of cautions, he may wind up going to a Trial Board and getting a reprimand.

Q On the basis of the cautions or a new offense?

A On the basis of a new offense plus the cautions. This is called the progressive discipline and as the person develops a record, why the purpose is to try to prevent further violations and to correct his actions and get him back into the rules and regulations.

Q So whereas a certain type of offense when looked at individually might not trigger a reprimand, several types of those violations in a series might?

A Yes. Take attendance. For us a person absent is a very costly matter. It could result in a delay of service to hundreds of people. It may also -- it also requires us to keep people over from one shift to another. He may have to work sixteen hours and it's not the safest practice in the world for having a busman driving sixteen hours or a motorman sixteen hours. Let's take a man who is absent. He works for two years, but he has not called up and a train is ready to go and it's a busy time of day. The motorman is not there. We have to

grab the first motorman in sight who has worked eight hours and he has to be thrown on that particular job. The fact that he has gone two years without an absence is to his credit, but the fact that he didn't let us know that he wasn't going to be in is a very serious matter. But having offsetting factors here we may end up with a caution for the first offense. If he continues that he may move up to two or three cautions up to a reprimand up to two, three days penalty and then maybe up to a Trial Board. Meanwhile, we have a system of counseling the man and to try to get him not to discipline but to do the job, get in on time, get in and do his job.

Q What type of conduct triggers a warning as opposed to a caution?

A I said, example -- I think it's largely semantics. In other areas they call them warnings and other areas they call them cautions. Getting back to the history, the Transit Authority is an amalgamation of several different organizations.

In the bus area, for instance, there were a number of private lines taken over by the City. The same is true of the Transit Authority. You may recall -- there are the three lines and at one time they were indepen-

dent. They had a certain nomenclature that was different. So you may find in one area they called it a warning and in another area they called it a caution.

Q So essentially then the cautions and warnings are synonymous?

A Yes. In some areas they may be a little stronger for a warning -- or a caution may have a little more effect than a warning but bas'cally we're talking about a sort of verbal first or second offense type of thing, minor.

Q What part have you played in formulating or deciding to continue the Transit Authority's present policy respecting persons with history of drug use?

A Well, I probably played a major role -- one of the persons involved in that area, yes.

Q Are you also responsibile for the alcoholism program?

A No. That was -- has been there for a number of years, but it does -- the function reports to me through my personnel director. I'm proud to say that it hasn't retrogressed, it has progressed since I've been there. Very good operation.

Q You have overall -- ultimate authority over the alcoholism program?

A Yes. It's a counseling service.

Q Turning just for a moment to the area of job descriptions. You described a process whereby Civil Service Commission personnel worked with your personnel -- people in the formulation of job -- I believe we're talking about the operations and maintenance of the areas of the Transit Authority. There are, however, a number of titles in the Transit Authority that are sometimes referred to as City wide titles?

A Yes.

Q People in the Civil Service Commission sometimes term them generic titles --

A I haven't heard it.

Q Do your personnel also assist in the formulation of the job descriptions for City wide titles in which people are employed in the Transit Authority?

A I can't tell you that. I know that this question of what is a proper title or not is carefully reviewed and we look at them, but you're asking me -- I'm not quite sure of your question. Let's take the clerical. A clerk title, for instance, what do you want to know about that?

Q There is a job description that is promulgated by the Civil Service Commission for Clerks?

A Yes.

Q The way you described the process previously, so far as it pertains to operations and maintenance people, it sounded like your people have some hand in what that job description says?

A Yes, we have a considerable --

Q Do you also have a hand in the formulation of job descriptions for clerical titles?

A I can't answer that. I really don't know that.

Q Do you have any reason to believe that you do?

A Well, if you are asking me do they go through the same procedure, I don't know that. But if we had a

reason to want to change what the City has said about a certain title, then we go talk to them about it. If we were different than they were, then we would ask that the title be changed to a Transit Authority title and how that is handled, for instance, -- take the title of analyst. Say the City wide title is "analyst", but we use the "analyst" title as "analyst T.A. The reason we couldn't use the City wide title is because it didn't relate to us. Yet some of the skills are similar, but the actual experience background, educational requirements, things of this nature, are different in the T.A. then say the Department of Welfare and so indirectly I have to answer your question by saying, yes, but in a general sense, no. But because what would happen is that we would get a separate title.

Mr. McLaren, I show you here a copy of a letter that was provided to us by your attorneys in response to our requests for the production of documents dated June 22, 1973. It's marked Exhibit D. That's the Transit Authority defendant's Exhibit D.

MR. BALBER: I'd like it marked as Plaintiff's Exhibit 2 for Identification.

(Whereupon, the aforementioned docu-

ment was received and marked "Plaintiff's Exhibit 2" for Identification as of this date by the reporter.)

Q This letter is addressed to Cheaster Hart, who is the chairman of the New York State Temporary division to evaluate the drug laws and it has a comfirmed signature of William Ronan.

MR. DUNN: Will you address that to counsel for Mr. McLaren before presenting it to the witness?

THE WITNESS: I have read it.

Q Have you ever seen this letter before?

A Yes.

Q Did you have any hand in authoring it?

A I reviewed it.

Q You reviewed it for accuracy?

A Yes.

Q I'm quoting from the letter now. Page 2 of the letter. Quote, the present policy of the New York City Transit Authority is not to employ individuals who are participants in narcotic rehabilitation programs". Is that an accurate statement?

A Read that again.

Q "The present policy of the New York City

Transit Authority is not to employ individuals who are participants in narcotic rehabilitation programs".

A Yes.

Q Now reading from page 3 of the letter, "It is the present policy of the Transit Authority not to employ or to retain those individuals who are participants in a narcotic rehabilitation program. We do not distinguish between those who have completed any rehabilitation program or are now on a program". Is that an accurate statement?

A Yes.

Q Mr. McLaren, are tests that are designed to detect the current use of illicit drugs given to all persons seeking Transit Authority employment?

A I don't believe we have ever said that it was to detect the usage of illicit drugs. Where -- of drugs --

Q Are they given to all prospective Transit Authority employees?

A Not over thirty-five.

Q But everyone under thirty-five?

A Yes.

Q Are these tests administered to prospective employees in City wide titles as well as T.A. titles?

A Yes, all titles.

Q Are they urine analyses?

A Yes.

Q Are all Transit Authority employees subject to regular periodic tests designed to detect their use of drugs?

A None are.

Q Are any Transit Authority employees subject to regular -- to periodic medical examinations?

A Yes.

Q Which employees are those?

A Mostly the crew -- the bus operators and the conductors and the motormen.

Q Dispatchers?

A No. I believe I'm right -- no -- dispatchers are supervision.

Q Are any periodic medical examinations given to any persons in City wide titles?

A No. They are only given to those involved in critical jobs effecting the safety and service of our system.

Q Then it's correct to say the criterion that is used to ascertain whether any particular job title

should be subject to regular periodic medical examinations is the safety sensitivity of the particular job title?

A That is one of them. We have proposed on occasions and we will propose again to broaden this, but this is a Union management negotiating issue. We would like to double or even triple the number of people on -- number of employees and the number of titles that have periodics. We are of the opinion that anyone working around the tracks or in controlling or directing our equipment should have periodic examinations. There are other persons who are involved in very sensitive areas that we would not give examinations. For instance, the railroad clerks and the porters. Two titles.

A Yes.

Q Could you, to the best you can, recall what titles they are?

A All titles that work around the tracks and on our structures.

Q What proportion of your titles -- of your T.A. titles would that be covered by periodics, if they are extended to that group?

A Over half.

Q What proportion are covered now, roughly?

A A third, maybe.

Q So that people referred to Dr. Trigg when their past use as well as their current use is in question, is that what you are saying?

A What I said is that if a person -- if a person is found to have -- be a user of drugs through the urine examination he is not referred to Dr. Trigg. If there is a question in the minds of our doctors because of evidence, either current or past, about a person, but no evidence in the urine, it would be referred to Dr. Trigg. I also think I stated that this was a very small number of people.

Q I believe you did. Dr. Trigg then makes a recommendation with regard to whether he believes, these persons who were referred to him, would be good employment risks in the Authority, is that correct?

A Yes.

Q Is his recommendation considered by the Authority to be the final determination with respect to eligibility so far as drug use is concerned?

A Yes.

Q Is the same true of current employees, you are referred to Dr. Trigg?

A Yes, if there was a question about them.

Q His recommendation is also considered the final determination?

A Yes.

Q To your knowledge, now, I realize there may be some situations you don't know about, but to your knowledge, are there any persons in the employ of the Transit Authority who the Authority knows at one time used methadone or illicit drugs while in the employ of the Authority, but are not now using such drugs today?

A If I understand your question, you said that if --

Q Let me clarify it for you. Are there any persons now in the employ of the Transit Authority --

to your knowledge, are there any persons now in the employ of the Transit Authority who have a history of drug use while in the employ of the Transit Authority but have no such drug use today?

A No, not that I know of.

Q Earlier in the questioning I believe I asked you the same question with respect to persons -- to your knowledge, are there any persons in the employ of the Transit Authority today who had a history of drug usage before being employed in the Transit Authority?

A No, not that I know of. If you speak of marijuana, we've had instances where people have been picked up and found to have possessed marijuana in their automobile or one thing like that -- excluding those.

Q You characterized several of your expert consultants that they wouldn't ride in --

A I didn't say "expert consultants" -- who we talked to in our seminars. We have only one consultant.

Q That's Dr. Trigg?

A Yes

Q Do you think that Burnstein Institute and the Beth Israel is a reputable operation?

A Yes.

Q Going back to the question that I asked you before your last response, not the "yes", but the explanation you gave. Your answer was "yes" with that explanation. My question being even though certain individuals might be suitable for Transit Authority employment because of the nature of the Transit Authority's operation you don't believe that the consideration on individual basis is feasible?

A I don't think that the Transit Authority should participate in an experiment involving the lives of several million people. I think there is need to know a lot more about drug rehabilitation just like there is alcohol rehabilitation or many other aspects of human behavior, but I don't think that we should be part of that experiment. We've had people from the insurance

companies come over to our seminars who have hired drug users, addicts and so forth and their experience has been miserable and they have hired ten or twelve of them, put them in one room under the eye of one supervisor.

Q What insurance companies were those?

A Might have been Metropolitan. It's been powered in the papers as being one of the forerunners in this, but the actual numbers of people were ten or twelve, not what you are asking us to do, in hundreds. Five per cent of the people we've examined have been drug users and this is up in the thousands.

Q Five per cent, you mean five per cent of the persons on the eligibility list for the Transit Authority?

A Yes. What are we to do with thousands running around our system -- I testified before that we have problems with alcoholics and the use of alcohol and problem drinkers. We're not set up to involve any drug experimentation. We are just not able to cope with it and handle it. Just the physical problem of taking urines -- what are we supposed to do, check everyday when we have people spread over the entire City of New York, whether they took their methadone treatment that day and he's

working at midnight out in Queens or out in the Far Rockaways? How are we going to get it? Who wants to have him take his methadone at 12:00 o'clock at night and have him work until 6:00 o'clock the next morning and he's a motorman or a conductor or he's walking the track and it gets late at night. How good is the methadone treatment at that point in time. Let's take another part of the aspect of maturing as we're told about methadone. The problem of constipation, the problem of sweating, excessive sweating. The problem of impotents and the problem of insecurity. Now, we're advised that this is a maturing matter and that it continues, do you know what the problem of constipation is to a bus driver or motorman or a person working out on the tracks where there is no toilets around. They resort to laxatives and do you know what that means when they are driving a bus or a motorman, what does he do, use his hat, stop the train? We can't have that. And this is a very difficult problem for people in the methadone treatments. Excessive sweating. You have been on a bus and seen the bus driver pouring with sweat. He gets claustrophobia. These are very serious personal problems to our people.

Q How does impotents cause a problem?

A The insecurity. If we had one test for a bus operator that would give us the ability of the person to sit on a bus and to face all of his hustle and bustle of the pressure of a crowd, we'll throw out intelligence and physicals --

Q You mean, the test for impotents?

A Inner confidence.

Q If you have a test that could definitively determine whether a person was impotent, would you administer that test for bus drivers or disqualify him? Would you administer that test to bus drivers --

A That goes to the heart of the certification program. You take a man that comes out of a shock -- a shocking experience like being addicted to drugs and suddenly detoxify him and thrust him out into the world and suddenly find he's sweating and impotent and constipated and he's unsure and uncertain. It is a harrowing experience.

Q That wasn't my question.

A If you go to the matter of certification, those who have advocated it, they speak of the psychological, the psychiatric, the social and the vocational and if they would get -- know something about the person, the person knows something about himself and how he functions

and things of this nature, I think you would have a better rounded program.

Q That wasn't my question. My question was, if you had a test that could definitively ascertain whether a man was impotent, would you use a negative finding on that test to disqualify that man as a bus driver?

A No.

Q Do you elicit information in your medical questionnaires regarding constipation?

A Yes. Do we? Yes, I believe we do have very serious trouble with constipated bus drivers and crew people. Very serious problems. We have most absenteeism than any other problem. How can a man come to work if he has constipation and has to resort to laxatives.

Q Do you automatically disqualify a person from being a motorman or bus operator because he has cronic constipation?

A If a person has diarrhea as a result of it, the answer would be yes.

Q In the absence of diarrhea?

A That I don't know if he's constipated.

Q Do you disqualify -- do you run tests to see if persons sweat profusely and disqualify him from

being bus operators?

A No.

Q Have you relied on any studies that you or your subordinates have seen and inspected to validate the Transit Authority's drug policy?

A What aspects of our policy are you talking about?

Q All aspects of your policy.

A Well, I said that we've had discussions with -- we've had these people in for our seminars. We have visited various schools and institutions and talked to persons and of course there is constant news on the medias. Reports by various public bodies including the City Counsel and various counselmen, Bergen and others who have brought to the attention of the public some of the qualities of the various drug treatment programs. We know something about our system, what we can't and can do. It's flexibility. However, it can be stretched. What can be done.

Q Other than oral communication with persons who have knowledge of drug addiction and other than reports produced by political bodies and reports that you've heard over the news media, have you relied on any tangible scientific studies to support the continuation of your policy?

A I have seen some studies. One indicated that the use of methadone is almost an heroic deed. It speeds the eye and coordination, better drivers, better citizens better everything.

Q What study is that?

A No.

Q Is your policy based on any statistics not contained in studies?

A What do you mean by that?

Q For example, you referred previously to the fact that your screening indicates that something like five some odd per cent of persons on Civil Service lists certified as being eligible for Transit Authority employment are discovered to be users of drugs. Are there any other such statistics that you rely on?

A Well, that's the only -- the answer is, no. We use our own statistics in this area.

Q I'm referring to your own statistics as well.

Q Is it the policy of the Authority to maintain records regarding the causes of its accidents?

A Yes.

Q Would those records indicate whether -- do those records indicate whether the employee or

employees involved in that accident were using drugs at the time of the accident?

A Yes, it would. The write-up would.

Q Are those write-ups ever put in summary form?

A Well, I answered your question once, that we do not have any drug --

Q I said, are those drug users put in summary form?

A There is no accident -- if you are asking me summary accidents, when I said there are no employees involved in accidents. You asked the incident I sited it was not an accident. It was no accident. He went down the street out of control, but that wasn't an accident. We wouldn't consider it an accident.

Q I take it from what you're saying, the accident reports that are compiled at this point in time contain no records of employees involved in those accidents having been abusing drugs at the time of the accident?

A I can't answer any more than I have because you persist on using a term that is not correct.

Q Do you --

A What is an accident to you?

Q There are certain occurrences during the course of the operation of the New York City Transit Authority, I assume, that result in reports being written by them -- accident reports?

A Yes.

Q What kind of occurrences occur in such reports being written?

A Collision, something of this nature. If someone is hurt, injured.

Q Are such reports written every time a passenger is run over by a train?

A Yes.

Q As part of the process -- approximately such records are written per year?

A I can tell you this, the number of people that are discharged as a result of drug use.

Q How many accident reports are written every year -- accidents for all reasons?

A Hundreds. Hundreds.

Q Thousands?

A Could be that much when you consider the buses running up and down Madison Avenue and every little touch and nick -- I don't know about thousands, but a large number. Remember, we have many, many vehicles.

Q You don't mean to imply that all those accidents result in severe injury to people?

A No, but they are written up as an accident. We must make reports on that. We must make reports to the National Safety Counsel. We must make reports to Police and many other areas, yes.

Q Every time a bus is damaged, in the course of its operation, that's an accident report?

A Yes. If a person is injured or a person is struck, that is an accident, and it's reported as an accident. That is what we mean by an accident.

Q Is it an accident every time there is damage of any sort to a subway train?

A Yes.

Q Is it an accident every time a passenger is injured?

A Yes. He falls downstairs, it would be an accident. It's so reported as an accident and the report is made out.

Q Is it an accident every time a Transit employee is injured?

A Yes. Every time he turns himself in for the smallest -- slightest cut, it's an accident, it's reported as such. That's for his protection.

Q When trains jump signals in tunnels, is that considered an accident?

A Not necessarily, no. Jump a signal, you mean go through a signal?

Q Yes.

A No. It's improper operating performance.

Q Each of these accidents is written up in a report of some sort, is that true?

A Yes. So would an operating violation.

Q With regard to the accident reports, as part of the compilation of those reports, are the employees involved in the accident routinely tested for the use of drugs?

A I believe I've already answered that. They are.

Q Do any of those accident reports, as we've just been discussing them, contain evidence -- scientific evidence from those tests that the employees involved in the accidents were abusing drugs?

A I think I answered that before, but I will answer it again. Not that I'm aware of, no.

Q As part of compiling those accident reports, are tests also conducted that are designed to ascertain whether or not the employees involved are using alcohol?

A Yes.

Q Do any of those accident reports as we've just been discussing them contain scientific evidence from the alcoholic tests that the employees involved in the accidents were using alcohol?

A We've had some, yes, very few -- some. I don't recall any in the Rapid Transit area, but I do recall one. I believe, at least in recent memory, in buses.

Q Do you have any idea how many?

A Very few. Very few. We don't have a bunch of drunkards.

Q I take it though that some accidents have been caused -- accidents with respect to accident reports have been caused by diabetes and epileptics?

A No, I don't know of any. I think someone said that we have a bus driver who was driving sometime -- I don't believe anyone was hurt, but he did die when he was driving. This can happen. That's why we give these yearly periodic examinations and that's why diabetes and any of the other diseases that cause passing out are important.

Q What is your policy with respect to persons whom you discover have diabetes or epilepsy?

A We would not hire a person who was diabetic.

Q What if you discovered --

A It's an absolute bar to the job we were talking about.

Q They were eligible for some jobs?

A Very limited. Shop jobs -- especially in skilled trades. Where some of the skilled trades, like a machine operator is tied to that job, don't move around.

Q A car maintainer?

A Well, a car maintainer is a broad --

Q Group "D"?

A What is "D"?

Q I'm not sure. I just know the other name. So car maintainers --

A Well, some car maintainers are -- like "E" is electrical and "E" may go anywhere and do and they may work on any shifts and do and they climb on cars.

Q Are there some car maintainers that do primarily sheet metal work?

A Yes. There could be some sheet metal work.

Q Would epileptics be eligible for that type of position?

A Sheet metal -- probably not, because they would be required to climb, but take the machine operator who works on a machine, yes. Again, though, there are certain machines he would not -- if he could fall into

the machine he would not.

Q Then excluding them from some jobs and not others, you seem to have two sets of considerations. One is protection of the public and the other would be protection of the employees?

A Epilepsy would be the protection of the employee because he couldn't work in area where he was involved with the public.

Q For example, the car maintainers, some types of car maintainers -- because some jobs are more dangerous than others to the employee?

A Car inspectors are out on the road because they inspect the equipment. If there is a breakdown, they are out there. If they are out on the yard looking at it -- they are like people who walk the tracks. They are out there.

Q What about persons who you hire without knowing they are epileptics or diabetics?

A We find out because they falsify it.

Q What if they didn't know they were diabetic or epileptics?

A We catch the people who develop diabetes right along.

Q What do you do with them?

A We transfer them to areas where they can perform. You have to change title. If I am, for instance, in a title where work could be found where I am isolated, then I would not have to, but if I have to move from one title to another thereby replacing a person on the Civil Service list who had a claim to that job, you have to have two years service. The other factor is we get so loaded with persons who can't perform work -- remember now we're talking about eyes, blood pressure, many other things that develop as to people who are with us for years, we have a limited number of jobs that are considered preferred or easy jobs that -- it might be an industrial injury too.

Q How many are there of such jobs?

A Right now we have probably 1,700, 1,800, but we'll vary between 1,500 and 2,000 of this category.

Q You mean 1,500 to 2,000 persons in that category?

A Yes. For instance, you may have -- for example, you work for us for fifteen years and you are a bus driver and gone over the weekend you injure your back, but you can perform work this might be a thirty day or a ten day or a one week -- we would try to accomadate you on a job which you could perform until your

back was all right.

Q To backtrack a little bit. Correct me if I'm wrong, you indicated that if an employee is discovered to have epilepsy, for example, let's use the diabetic -- discovered to have diabetes, he can be transferred to a limited service position --

A Let's go through it. Say he goes -- his periodic-- he's a bus driver, he's a diabetic. The first thing is go see your doctor and go through the tests and examination and the doctor may come back and say or the hospital that this man can by doing this, perform a normal bus driving operation. Diet and medication and so forth. So as long as he stayed on his diet and took his medication and we would periodically check, he could be a bus driver, but let's assume that the hospital says that for five or six months until we release him he should not--he's restricted. Our doctors would then look at it and say what he could or couldn't do and if we have work that he could do we would transfer him to that job even though it's out of title. For instance, we might put him over as a railroad clerk. For example, we might have persons with severe diabetes on another job like railroad clerk. If he isn't too bad -- there are some diabetics that are so bad that they can't work

at all until they get it under control.

Q Is this done for people no matter how much seniority they have?

A No. They have to have more than two years.

Q If they have less than two years they can work, as long as it's in title, not out of title?

A If they can perform the work within the title, but the work that -- then they would be put into that.

Q Like a conductor taken off a train and put on the platform, for example?

A No. I don't think they can do that. It's a picked job. That's a Union situation, a conductor. Let's assume this man has been diagnosed that he should be -- the medical department says that this man isn't ready for -- to be a conductor, he needs further treatment and we recommend that he go off an operating job. We might switch him to railroad clerk, we might switch him to porter, if it wasn't a physical part of the job. We might switch him to any -- even a semi-clerical job. We have many operations that are semi-clerical. Accounting, traffic, scheduling. Many, many jobs of that nature. I'm not the best person in the world to describe this because this is something that has been done over the years and people know where to go on these various

jobs. They have been established. But it's a technique that we have.

Q You stated that there were some 1,700, approximately, people?

A Yes. Various stages of this. The man who hurts his back on the weekend or is in an automobile accident or he may be injured on the property, he may have permanent disability such as the bus driver who has high blood pressure, too high to drive a bus. He may have to be switched. You used the example of epilepsy or diabetes. All of the ills a man -- our people have.

Q These epileptics are considered -- or diabetics are considered for certain types of jobs?

A Jobs that they can perform depending upon their condition.

Q And the criteria for selecting these jobs is that they won't pose a danger to themselves or to the employees --

A That they can do the jobs.

Q But the actual selection of the job is based --

A Again on what they can do. Again in doing this job they would endanger other employees, the public or themselves, they wouldn't be put on that job. We would find a job where they could perform.

Q These are jobs of the type where if an employee blacked out or had a seizure he would not be posing a danger to the public -- an immediate danger to the public or an immediate danger to himself or other employees?

A Yes, and there would be people around and see him and could treat him.

Q You told me there were 1,700 employees who were placed in jobs of this sort?

A Not exactly. You are using the most extreme case. I also said there were people who injured their back on weekends who had automobile accidents or they are injured on the job.

Q Some employees that were placed in jobs of this sort?

A Yes.

Q Are there also jobs of this sort in the Transit Authority that are currently being performed

by persons who are completely competent physically, who are not diabetics?

A Yes, they are the oldest service employees because they are the preferred jobs. They feel cheated because they don't have those 1,500 jobs. By the way, it's a very difficult feat to negotiate with Unions and take from them these very -- we call them tit jobs -- they broadly refer to them as such -- take those away from persons who could pick it on the basis of their service or longevity and give it to people who have much less service, that very often may be moving them from an afternoon to a day job and --

Q How many such jobs are there --

A Well --

Q (Continuing) -- that are not now occupied by the 1,700 employees?

A I said we vary between 1,500 and 2,000.

Q You're talking about employees with non service disability. I'm talking about the type of job where the employees failure to perform a job would not cause a --

A I don't know. You see, some of them are railroad clerk jobs. We have five thousand railroad clerks that is not a particularly preferred job, but if I was a

a bus operator and it was a chose of staying home while I'm getting my treatment as a diabetic, I would go on the railroad clerk's job. So there is a number.

Q You place epileptics and diabetics --

A I wouldn't say that we would place epileptics because they would pass out in a booth and who would know it. They are not under observation. Besides what would the public do, he's foaming, he's swallowing his tongue and he's dead.

Q Do you place diabetics in as railroad clerks?

A Yes, depending on their medical condition.

Q What other titles do you place epileptics and diabetics in?

A Well, to get back to the point I made, it isn't necessarily title, it's the duty or jobs within the title.

Q What areas within what titles do you place?

A There are many areas. For instance, motormen sometimes at the end of the line where they go from one run to another or one station to another, there may be semi-clerical or jobs there for motormen. We have things like taking care of the radios, that they have to pick up and put back and this sort of thing. There are motormen who may be assigned those duties. So we have duties

like that. There is the pulling of the change boxes on the buses and the handling of that. We have them on guard duty sometimes in the wintertime when we have the big doors that open and shut. We will sometimes have people there so that it's hurried up, if it's a cold day. There are many jobs of that type in an organization this long. Consequently, there are a great number of these jobs, but those are very prized jobs and bid on by persons.

A Our turnover is very little. Our total turnover including retirement, I think, is about 5%, somewhere around there.

Q Can you also tell me how many people are fired because it's discovered that they have epilepsy or diabetes or some other nonservice connected disability -- fired because there is no limited service positions for them to be transferred to?

A Well, let's go back to definition again. If they have two years or less -- or less than two years, they are terminated -- they aren't fired, they are terminated I believe, for medical reasons. If they have more than two years, they are placed -- we place them.

Q You guarantee them a place?

A Yes. If again their condition is such. Some may have stayed out for some period of time, but they can come back.

Q We went over the drug policy extensively before. Does that same policy pertain to MABSDOA?

A Yes.

Q It's identical in all respects?

A Yes.

Q Does the drug policy as we discussed also pertain to City wide titles as well as T.A. titles?

A Yes.

Q In all respects?

A Yes.

the job, his years of service, et cetera, things of that nature, but, briefly, if he is in a critical job such as a motorman, for example, he would be immediately removed from that job, probably suspended and, well, I will go back one step. First we would establish that he had been drinking, and under the rules just alcoholic breath is enough to establish it. Then we go on from there with other visual signs such as bloodshot eyes, poor co-ordination, and, more important, we have a test that is administered by hospitals in the area to determine the blood content However, that is not necessary to establish drinking. It does eliminate much of the wear and tear of what goes on in the grievance procedure to do that.

He is then removed from the job and he can go all the way to being fired. He may be suspended a minimum of a year-- excuse me, when I say that, it goes to the Trial Board, and if the case is proven he would be demoted up to a year to another job. He may apply within a year, if this is the first offense and it is apparent that it is a random type violation. However, if this is one of the serious problem drinkers, or even alcoholism, it would be a minimum of three years before he can apply. He then would be referred to Counseling Service where the matter of his cooperation with Counseling Service is a very important consideration on what happens to him in the future, and he may also be

required to continue his suspension and attend one of the places--Mt. Carmel is an examole, or he may go to other places, and this is on his own. He is not paid, nor is he permitted to receive medical payments from the fund for that. After he has established himself there, he comes back to the Medical Department and if he is medically fit, he can go back to the demoted job.

Basically, we require abstinence. If he does not abstain--

Q Now, are virtually all emplovees of the Authority who are discovered to be drinking on the job summoned for Trial Board hearings or subjected to departmental hearings?

A Going back to the job, once again, they are all subject to Trial Board. Now, there may be rare exceptions that I am not aware of, but that could happen.

One of the problems of dealing with drinking is that you have this sympathy among drinkers when one gets caught. You have the hiding of the person who has a drinking problem. In the case, however, say, of a person on a non-critical job like a car cleaner or even a person who may be a car maintainer, if the job is of a nature that the drinking would not directly relate to passengers' safety or overly expose other employees, he may be disciplined within the department the first time, and the second time he will go to the Trial Board.

Now, again, on drinking, I want to bring up the point that length of service, past record, all of these things occur.

Holidays, for instance, there are people who will have a drink, then will not take any the rest of the year. We had that during war time. We have problems with drinking when sons return. Father will have a drink, and so forth. They may never have had a history. These things are considered, but there are penalties for them.

Q Now, I believe you mentioned car maintainers and car cleaners as examples of two categories of people that won't initially for the first offense be summoned before the Trial Board in most cases.

A I use them as examples of jobs that may not be directly related to passengers' safety or to other employees' safety.

Q O.K. Well, are there other jobs that fall into that category?

A Yes, there are a number of other jobs that would fall into that category. I would say that probably 60-40, 50-50 on the property, about half of the jobs fall into that category, half do not.

Q Give me just a few other examples.

A Well, of course, the more I use that as an example-- I would say the car cleaners and probably the railroad clerks

and the porters in some areas. You see, you are dealing here with a matter of judgment. Those are big areas.

Q It is a matter of individualized determinations?

A For instance, I use the term "maintainer". The maintainer could be operating a crane, another man may be working at a bench. One man may be working out on structures. Another may be in an electronic repair area on the bench. Again, I say that this is a variation.

Some bus maintainers are required to drive buses. In that sense they are on emergency call. He may be going out and then be required to drive the bus back. The maintainer would have to drive it back when it is out of repair.

Q So then what might stereotypically--someone with a rather bad problem--he might be referred to Mt. Carmel initially and then come back to the Transit Authority for a demoted position for three years?

A In these critical areas, yes. Some people would go

voluntarily, I suppose.

Q How is the stay at Mt. Carmel financed?

A They finance it.

Q Does the Transit Authority loan them the money?

A We could lend them the money, yes.

Q Do you loan them money?

A I believe we have a program for that. It is a short stay, you know, relatively short.

Q What underlying policy provides the basis for the alcoholism program? What reasons do you have for maintaining it, generally speaking?

A I cannot tell you why it was started, but I assume it was started for the same reason that other organizations started programs, in an attempt to work with the various national programs of industry and government to do this. There is a certain self-interest in it, too, to reduce absenteeism and the effects of alcoholism.

Q Now, if someone has a drinking problem, at least if someone perceives that they have a drinking problem, an employee of the Transit Authority, and they have not been caught drinking on the job--at least not yet--are they eligible to come in on a voluntary basis to your Counseling Service?

A Yes.

Q Now, is that kept on a confidential basis?

A It is kept on a confidential basis.

Q If he came in and admitted he had a drinking problem, but it did not manifest itself on the job, would he still be permitted to remain on the job, assuming he had a critical job?

A If he does not drink on the job, we would have no other way of knowing whether he drinks or not except if he doesn't come to work or he shows the effects of his drinking, but, again

we get back to a definition of if a man is an alcoholic and he shows he has symptoms, very serious symptoms, including liver damage and other physical damages, it is not difficult for a doctor to diagnose that. However, if you go into problem drinking, social drinking, many other categories, then you are dealing with another facet of the problem drinker.

Q Let me see if I can phrase it differently. Does the Authority make an attempt to ascertain whether employees are drinkers or does it merely look to the performance on the job as a criterion to determine whether or not they should be removed from the job because of their drinking?

A Our concern is the performance, and the individual-- strike that. I don't know what his concern is; our concern is performance, and the way we would find out if a man has a problem is his performance. He doesn't come to work or he is late or he is sloppy, poor performance. He is not alert. He is under the influence or he is drinking. He requires alcohol as a part of his subsistence. That is how we get into it. The question of a man drinking off the job, we really are not involved in that. We would not know it. There is a great degree in tolerance. What one man can consume in all of his life would put another man in the hospital.

Q Is there a minimum period of seniority required before

someone is eligible to be fired because he is found drinking on the job?

A No. Anyone--

Q Suppose someone who has been working for the Authority for a month is found drinking on the job, he--

A He would be in his probationary period.

Q And he would be dismissed?

A Yes.

Q How long is that probationary period?

A It is six months. You may recall--I believe we discussed this in connection with other transfers, the question of moving people from one job to another for any reason. You cannot move or be transferred for drinking with less than three years of service.

Q So then someone in a critical job found drinking who had been employed by the Authority for less than three years would be subject to dismissal, but someone in a non-critical job would not necessarily be?

A That is correct, if he can perform his work, but this is the same as we discussed for other categories such as diabetes and epilepsy.

Q Are persons who--I know it is very difficult to look at a man medically or in any other way unless he has had liver

damage or something of that nature and ascertain whether or not he has a history of alcoholism, but if he is no longer an active alcoholic, is it the policy of the Authority to consider for employment persons who it knows have a history of alcoholism but currently have apparently recovered?

A Well, again, it would go to the job, the recovery, the stability record and all of that. When he gets into the matter of alcoholism, it is not likely a person would recover from alcoholism without physical damage. If a person had a history of alcoholism for a period of time and he came up, say, for a motorman, he would have a difficult time, I think, of getting hired. It is possible if it was a long period of time and complete recovery that he would be hired.

Q I suppose it would be easier for some other position, depending upon the nature of the duties that are performed there.

A The history of stability--it is not an absolute bar, but it would be a very serious matter to consider. It would be given great weight.

Q You look at various criteria, the period of time, and perhaps other jobs he has held, family background, things of that nature?

A Yes, but, again, I don't know of anyone that has come in and said, I was an alcoholic ten years ago, or fifteen or

twenty years ago if he weren't a serious case. Looking back, the younger people will get into problems and quit drinking after three or four or five years. They would have a very serious job, but I don't think there would be any physical damage, and for years they don't drink. I am sure that they would not call themselves alcoholics. Again, the matter of alcoholism, if you listen to people like Mt. Carmel which probably has had as much experience as anyone in the country, they feel that maybe a chemical disorder enters into it in that personswho have it have no control. It just happens to them. So if you have a family history of it, well, they are convinced they can show a physical reason, a chemical imbalance, and that you should never drink, not two drinks, not one drink. You have something within you affecting the tolerance side. There is also the feeling about people who--witness the problem of the Indians with their drinking.

This is a subject where, I guess, not too many people have paid enough attention to it. You are asking me questions probably beyond my capacity.

Q I realize that. I would just like to follow up with one more question. You mentioned that the young person who might drink for a few years and then might give up, you would consider them for transit employment, I would assume, at some

point in time depending on the individual case.

A Again I don't know. I have never heard of anyone coming in and saying: "Look, I am forty-two years old, but when I was eighteen or nineteen I had a drinking problem and I quit drinking."

I think most people find their level of handling alcohol, whether it be very quiet or was, but they find they cannot drink too much without getting drunk, and then they quit.

Q We would like to understand just a bit better the method of supervising, the general methods of supervising Transit Authority employees. For example, there are certain titles that you consider supervised positions, certain titles you consider, basically, unsupervised.

A You are speaking now about hourly employees?

Q I am talking about employees generally in the Operations and Maintenance Divisions.

A You have to give me a better description.

Q For example, are car maintainers generally, do you consider them supervised?

A Well, car employees are supervised. They have a supervisor, and like all large organizations we have various levels of supervision. We have the first level, and in maintenance it generally is called the foreman. You have the E Group, the A

Group. The number in it will depend upon the job conditions, the skills and things of that nature. It might be from several to ten or twelve.

Q Typically will a foreman inspect the work of other maintainers at intervals during the day and observe the job?

A Not necessarily during the day.

Q Or at night or whatever time?

A The period of time, it depends on the type of work, if it is stationary, like at a workbench, a repair shop. He may be stationed right in that area, immediate area. He would see people all through the day from time to time, and then, again, if he is involved with the maintenance work on the track or signals or structures or on the equipment, he may see them only occasionally. As a matter of fact, he may only see them at the beginning of the shift or the end of the shift, or maybe only once or twice a week.

Q Well, what methods do you have for keeping track of the employees, is he only seen once or twice a week?

A He reports to a work station and he is dispatched out. He may have an area that he patrols, goes from one point to another, like on signals. He has a specific area where he would go from one signal to another to do preventive maintenance or he may have work orders where he would go out and make a repair.

Q Does someone at some point follow up to make sure he has done the work?

A Well, again, yes and no. If I have an area from X point to Y point that I patrol daily, or I go in a cycle on a weekly basis, I am back at each one of them in a week or two weeks, whatever the cycle is, the answer is that the foreman may visit that area once a week or twice a week, again, depending on the type of job, but no foreman is required to check every single job a man does. He is a skilled man. He is supposed to do the job. Part of his job is to supervise and to check the work occasionally.

Q What if something critical, like, for example, a signal is out of order; you dispatch a maintainer to repair the signal. Does anyone check to make sure it has been repaired properly?

A A foreman, if it is critical, might accompany the signal man. We may send out three or four men, and the foreman may go with them. On the other hand, if it is routine, the helper or signalman may do it themselves.

Q The degree of supervision in part is based upon the critical nature of the task which has to be performed?

A Well, I think we figured there were 10,000 lights or signals in the system, a great number of them, and over the years

that would become routine, and just like the City lights on the streets, there are thousands of them, and it is not necessary to send a maintainer out and then a foreman right behind him to find out if he does the job. These are all monitored by central controls, and if the signal is out, it shows it is out. When it comes back in, central control knows that.

Q Central control monitors other systems in the tunnels like ventilation fans?

A No, I can't tell you that. You are getting over my head. You should have someone from Operations, but I don't believe so. I am sure there is a panel board somewhere that would indicate whether the fans are working or not working.

Q The same, I suppose, would be true about drainage equipment, for example, pumps and things like that?

A Yes.

Q Is the buddy system ever employed to keep track of employees working in isolated spots?

A There are areas where two men will go.

Q What would be a few typical areas?

A Tunnels and things of that nature, dangerous areas.

Q So they will assist and keep track of each other?

A Well, not only for that--that is one reason. There is the condition of the job, and many jobs are two-man jobs.

It could be when you are in an area such as that, you don't, really don't know whether it is one man or two men. So very often you prepare for the worst. I think I pointed that out to you, that the key to our critical problem is our ability to respond to it. We often over-respond. As a matter of fact, we are built, we are organized to over-respond. As an example, say we have a stalled train. If you analyze why the train is stalled, in some cases there is no problem to it, but in other cases there may be a rare instance here, but when it happens it is of a very serious nature. Therefore, we have to man-up for the worst. If the train stalls, we have to man-up to be able to respond to it. We have to man-up to respond immediately to serious conditions rather than a lighter condition, because of the number of passengers that would be involved in a condition such as that. So we will have what you were referring to, a buddy system. I might say it is an over-response.

A I think most jobs are of that sort obviously, all of our operation and maintenance titles are special to the Transit Authority. They are not City-wide titles. I think I was pointing out that there were other areas that because of the specialization and the peculiar nature of the work, it can be identified as Transit Authority titles. I used the example, I believe, of the analyst. It is a City-wide title. It was a City-wide title, but as our needs became established here, it was changed to a Transit Authority title.

Q What is the process by which a title is changed to a Transit Authority title? Is it formalized, a formalized mechanism; take a ruling by the City Civil Service Commission?

A Yes. That way it would be formalized, but it is not a very formal procedure. It is a series of conferences and one thing or another until finally there is an agreement that there should be a Transit Authority title.

Q Agreement among your personnel people and the City personnel people?

A Yes.

Q And then on some sort of formal action by the Commission, that changes the title?

A I don't know what they do. I don't know about that.

All I know is we get an understanding with the City, and then later on we are notified of it.

Q Do you know what percentage of your employees are picked up on those as drug abusers?

A It was running better than 6 per cent for a couple of years, and it is down to around 5 now. There seems to be a dropping off on the use of heroin--at least the use of heroin only, but some titles are still running 6 per cent or more, like

bus operators. I believe trackmen are high. I don't have all of it at my finger tips, but we have only the individual titles, and they run around 6 per cent. The figure that I was using, somewhere between 4 and 5 per cent, is for all titles, and they include clerical and professional, which are lower than others, but it is a substantial number.

Q Would you consider it proper to utilize the one-in-three rule to eliminate someone from employment with a history of drug abuse?

A Certainly, not only proper, it is legal. It has been upheld recently. No one on the Civil Service list has the right to the job. That is what the Supreme Court of the United States said. They just had a right to a place on the list. It doesn't guarantee them a job.

Q Have you exercised it to date to eliminate people with drug abuse histories?

A Oh, yes, I am sure we have. We have used it for people we would consider important employment risks.

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK
----------x

CARL A. BEAZER, ET AL,

vs

NEW YORK CITY TRANSIT AUTHORITY.

----------x

EXAMINATION BEFORE TRIAL OF

JOSEPH M. WARREN taken at the Legal Action Center of the City of New York on January 24, 1974 at 271 Madison Avenue, New York, New York before a Notary Public of the State of New York.

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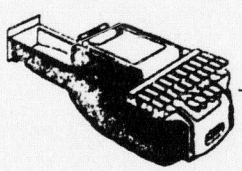

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16 COURT STREET • BROOKLYN, N.Y. 11241 • TR 5-2442

Q What is your name?

A Joseph Warren, Director of Employee Counseling Service, New York City Transit Authority.

Q Would you describe generally what the

counseling service is and what it performs?

A Generally speaking, the Employee Counseling Service is an organization that is set-up to provide assistance for problem drinkers in the transit system. When a situation comes to our attention, that employees drinking has interferred with any transit authority business, we refer him out for treatment. It is in the hope that it will not repeat itself. With this education process that we have, we have been able to successfully recover approximately 60 per cent of our employees before they have gone down the drain. We follow-up to see that they maintain their treatment. We rely on Alcoholics Anonymous. All of the referrals are not necessarily alcoholics. We don't diagnose alcoholism. We send everybody out to Alcoholics Anonymous meetings for educational purposes. Some of them will return and we become familiar with the seriousness of their drinking through their own admission. We have been able to really assist them in obtaining this knowledge.

Q What is that rule?

A No employee is to report for duty with alcoholic breath, nor is he supposed to bring alcoholic beverages on the property. It is in violation of this rule and it

is subject to discipline.

Q Are people that violate this rule, are they automatically fired from the Transit Authority?

A There will be some discipline involved.

Q What is the typical case? What usually happens?

A If a fellow is observed by the supervisor to be on duty unfit, his time is cut and he is brought out of service. During the hours of 8:00 a.m. and 4:00 p.m., he is brought in a clinic at Jay Street, 370 Jay Street for a blood alcohol test. If the test proves positive it substantiates the supervisor's findings that this man is unfit to perform duty at that time. During the off hours of Saturday and Sunday, he is brought into the designated hospital for the blood alcohol test. He is then picked up and brought into our lab at 370 Jay Street for analysis. If such test proves positive, this man is then referred to the Employees Counseling Service. We will have an interview with this man at this point. We will be able to determine how serious his drinking has become. How the importance that it has in his life, his knowledge of alcoholism and then we will refer him out to Alcoholics Anonymous meetings for insight and education so that this would not become a repeat offense. We feel

that with education, he will be able to deal with the problem in a more constructive manner. Sometimes if the fellow feels that it is not a serious problem that with education that they can obtain through the medium of AA they are no longer complacent or, their attitude has changed that it is not a repeat occurrence. Job performance is up to par. There is no relapse and it does not happen again so we feel that it is a success. They honestly feel it is not a problem. In the process, some fellows will come up or arrive at the conclusion that alcoholism is a very serious part of their lives. Through their admission, they will admit that it is a serious problem, and they are deeply concerned and want to follow through. We have a follow-up that everyone is to return to our service at the rate of once per week minimum. They are required to attend X amount of meetings according to their working schedule. If they are working 8 to 4, they have to attend 3 AA meetings a week. If they are working at 12 to 8 they are required to attend at least 2 AA meetings a week and if they are on the P.M. tour, they have to attend at least 1 AA meeting a week and return to our office once a week. They are to apply this procedure for approximately 3 months on this schedule. At the end of such time, we will expand the

treatment. We will expand the visit perhaps one every two weeks or once every three weeks and this will continue for ten months to a year. If during the course of this time, some of the fellows are sick or AWOL, we have the privilege to visit their home to find out what the situation is. If we find that there under the influence or not able to function, we will perhaps put them into a hospital. We know that compulsion has set in and we are trying to arrest the compulsion and break the cycle. At the end of such time, which is a 5 day treatment, they are to return to duty. We feel that occupational therapy at the time is a very essential part of their recovery.

Q When you first begin describing how people got into your program, I believe you said that supervisory people who they think are drinking on the job, then they have to go for a blood alcohol test?

A Not necessarily drinking on the job, but they report for duty unfit. Everyone is not drinking on the job.

Q They can show up in the morning?

A Anytime of the day unfit. The alcoholic does not necessarily report for duty as a result of drinking the night before. He could bring it on the property

unknown and he can slip drinks on the job and they can show up anytime of the day.

Q If someone shows up on duty at anytime of the day and appears to the supervisor that he had been drinking --

A Yes. People are not allowed to drink on their lunch period. They're getting paid for their lunch period and they are not supposed to indulge at that time. If they do show up or are observed drinking on their lunch period and they report for duty they are still unfit for duty if it comes back in a positive sense. Some employees have been known to have been drinking one beer.

Q Now, does everyone who has positive alcohol in his body have to enter the program in order to keep his job?

A Everyone has to more or less report to the service. It is more or less a voluntary situation. No one has to comply with our request. This is not a requirement for keeping jobs or anything like that. We do not fire people because they are drinking but if it becomes a repetitious situation perhaps as a result of poor job performance, perhaps over a course of time perhaps they will lose their job if they do not respond in a positive sense. We don't fire people in the Transit Authority just because they have been drinking

beer on their lunch hour but we feel that people in that category, people who have 8 hours to perform and 16 hours to do as they see fit, and if they can't abstain from alcohol for a period of 8 hours, they are definitely following a pattern of a problem drinker who can't abstain for such a long period of time. So therefore we don't diagnose. We refer them out. They develop an insight

Q What about the situation of someone who is referred for tests and he has more alcohol in his system and he has never been referred before. What happens? He is sent to you and he doesn't want to be in

AA and he doesn't want to be referred. Is he fired?

A Not necessarily. If it is just one of those things, if he has had a pretty good background, no other violations on his record, perhaps he will just have to face a departmental hearing. The maximum punishment would be a 3 day suspension.

Q Have you known of any instances where people have been referred more than twice and haven't had any other disciplinary violations and have been allowed to remain on the job?

A Yes, I have known of some, but most of them will respond to treatment at the very beginning. Most will respond with a certain amount of enthusiasm. Some where along the line, they may have other problems that they can't adhere with the program. Sometimes they have relapses. It will show up again on the job. We evaluate their interest and their attitude and the efforts that they have exerted to collect their situation. We make allowances for it. We are flexible in that area. Some people were just more or less go through the motions

or something of that type and we are able to detect that too. It becomes a repeat occurrence and it will lead to very serious consequences.

Q I assume that sometimes people are fired from the Transit Authority because of the drinking alone, is that correct?

A Yes.

Q How is it determined that they will be fired?

A Sometimes they have to appear at the trial board hearing, and drinking coupled with other situations, maybe their poor job performance, violations for attendance, this coupled with the drinking at the trial board hearing and perhaps the hearing referee may say that this is a final warning. That any other incidents related to drinking will lead to your dismissal. This is his recommendation for dismissal.

Q I see, so in those instances he is given one last chance, is that correct?

A Yes.

Q Now, if someone is known to be a heavy drinker off the job and somehow a supervisor finds out, that that someone is continually drunk off the job, is he referred to you for consuling too? He is sober on the

job?

A We are aware of many situations that have been off the job. Referrals from families. From other people in the program. We become aware of situations through other facilities. But if this man is drinking at this point and is interferred with Transit Authority business he is not immediately referred, but we will watch this man very carefully. Perhaps when he takes off sick, we are going to follow up on this. We will visit the home and find out what the condition really is. If he is under the influence now, he is obliged to enter our program.

Q The purpose of the visit is to help him, is that correct?

A More or less to help, yes.

Q Do you consider your job discipline when you visit the home? Do you go there as therapy?

A As a counsel to help the man. We don't initiate or do we recommend any discipline for any employee. Mostly to help him.

Q So if someone is in your program and you know he is not really genuinely interested in rehabilitating himself, you don't tell his supervisor about it?

A Of course not. We have a confidence situation that we don't really have to feed back to him because it will show up anyway. When a man responds positively it shows up.

Q So you leave it up to the supervisor?

A Yes, to refer him, yes.

Q Do people sometimes come into your program and say, "I've had a drinking problem," and say, "I need help."

A Yes.

Q Do you tell the supervisor?

A It is strictly confidential highly classified information. Volunteers are highly classified information.

Q If a supervisor asked you about someone who was in your program, would you tell him?

A If there was no record of his alcoholism

interfering with Transit Authority business, we won't give it out.

Q Does everyone have to except a job demotion in order to become part of your program?

A No.

Q For example, what if a conductor or a train conductor came into your program and a supervisor had not referred him, this man was coming in voluntarily. Would you then tell the supervisor or that this man should be taken off the train?

A Of course not. It is highly classified information. No one in the Authority would become aware but us. We have to have a certain amount of confidence in a man exposing himself to us. He is usually referred to us by a member of the program. This is what we try to do. We assist.

Q Is this confidence a necessary part of rehabilitation?

A Yes, it is.

Q What about the situation where the same conductor supervises or smells alcohol on the conductor's breath and he refers him for testing, but the conductor doesn't have any violations relating to his operational performance, is taken off the train?

A When you say taken off the train, are you --

Q Is he demoted?

A It is more or less a motion at this point. If he has signed on and is operating our equipment at that time, he is restricted to a limited position away from the passengers and so forth.

Q So you have had conductors that were referred by supervisors and then put in positions of platform conductors?

A Platform duty, yes.

Q But if the supervisor hadn't referred the person, they would stay on the train?

A Yes, they would.

Q What other kinds of restricted positions like platform conductor people with alcoholic problems are allowed to be placed in? Give some examples cf jobs they are allowed to have?

A I don't understand the question. This is a critical position.

Q I believe that you said that this person would be put on platform duty?

A Yes.

Q I assume, is it correct that platform conductor is not considered a critical position?

A He is not in a position here to jeopardize the safety of our passengers at that point.

Q What other positions do you consider similar to platform positions where people in your program work?

A They would be classified as critical.

Q Not critical.

A Maybe clerical people or maybe some maintenance shop people.

Q Car maintainers?

A Maybe working in the shop, yes. Railroad clerks. Porters. Some caretakers, watchman. People who are not directly involved with passengers.

Q How about somebody like a ventilation and drainage maintainer?

A I don't believe that he is working along with high voltage. That would be a critical position.

Q What about trackmen?

A Very much.

Q How about turnstile maintainers?

A Not necessarily.

Q Would any of the clerical jobs be considered critical?

A No.

Q So after he goes to the medical department, the supervisor can decide whether or not he wants to restrict this man's duty, is that correct? What is the process that is decided that the man is to be taken off the critical position?

A If the test comes back positive it is more or less that he has violated one of the rules and that he is unfit for performance in that critical position.

Q Is it the supervisor who decides to restrict the person or is it a medical direction?

A At that time, the supervisor is not allowed to have the perform in this same position. He has to appear at a disciplinary hearing as a result of this and the recommendation of a hearing referee plus other people in the Authority make the determination to whether the man is to remain in that known critical position.

Q In the case of someone, let's say someone is put in a known critical position, do they decide that the person should be able to Transit Authority in a restricted position and let's say that same person is participating in your program and going to AA meetings according to schedule that you think is best, does there

come a time when he can go back to his former job to the critical position?

A Yes, if he has applied himself well and we are very sure that this man has achieved some level of ability. We are aware that he is drug free. He has both feet solid on the ground. No further violations. If you request restoration and he has been in total cooperation asfar as we are concerned we will state the progress as we understand it and certain factions in the Authority will weigh them and will make certain estimations as to whether he returns or not. We only state the facts.

Q It is all done on an individual basis?

A Yes.

Q Is there a minimum time period that you employ some in your program before he is allowed to go back?

A It is more or less a 3 year period that he is restricted to that lesser position, non-critical position. More or less 3 years. We must be thoroughly satisfied. And when I say that, we know that this man is actively engaged in the program and not just attending meetings. We have to realize that he has reached a new set of values. Not very much at liberty to discuss the things

that he was withholding from himself at that point. We feel that he can face himself honestly. This man is an expert on alcoholism asfar as his own personal drinking is concerned and he is just not a person who has just attended meetings say for three months and knows absolutely nothing about it. No change in attitude or personality or anything of that type.

Q Are there cases where people are allowed to go back to the non-restricted position in less then 3 years?

A I've heard of one or two that they have been restored under 3 years, but I am not too sure what the situation was at that point.

Q Do you know if it was after a time period of one year in any case?

A Yes. I do know of one case there but this man had followed the procedures 100 per cent asfar as we were concerned and this man persisted that he had no drinking problem that he was deeply interested in what we had suggested to him and we honestly felt that alcoholism was not a very serious problem. Everyone that we encountered does not have an alcoholic problem and we were sure that he was not an alcoholic.

Q People in the employ of the Authority

have to have a certain minimum period of seniority before they are allowed to stay on the job when it's known that they have a drinking problem? If a man has been working two years and it is discovered that he has a drinking problem if he --

A Not necessarily. A person that has been on the job for 4 months or 5 months, he hasn't yet met the probation requirements, and if drinking has been exposed on the job, then he doesn't meet the probation requirements.

Q What is the probation period?

A 6 months.

Q Are people automatically terminated?

A Before 6 months? After 6 months.

Q Not automatically. They have to face discipline after 6 months.

If someone has been placed in a restricted position because he is an alcoholic and in your opinion after a period of time, he has successfully done with his problem, can he be reinstated to his former position no matter what the position was?

A It is possible, yes.

Q What kind of positions are successful graduates of your program employed in?

A Every position in the Authority have been successfully filled.

Q Tourmen?

A Yes.

Q Do you cover Manhattan, Bronx surface operating authority?

A Yes, they come under our direction.

Q Have there been instances of people that have gotten jobs as bus operators?

A Yes. They have a different set of procedures then we have at the New York City Transit Authority.

Q Are they allowed into positions where they deal with high voltage?

A At MABSTOA?

Q No, at the Transit Authority.

A Yes.

Q Have people been allowed to retain positions as trainmasters?

A Never known of a trainmaster who has been demoted and restored to title.

Q Trainmasters that have been alcoholics?

A Oh yes. Perhaps the Transit Authority is not

aware of these people.

Q They are the people that you referred to before that come in voluntarily?

A Yes.

Q They are allowed to become trainmasters?

A Yes.

Q How about dispatchers?

A Yes.

Q Are both types of people serving as dispatchers? The people that have been demoted and then reinstated?

A I'm not familiar with any dispatcher who has been demoted and restored to dispatcher. I am not familiar with any situation of that type. We have people who have ended the program. These are the people who have been taking promotions and have reached the level of dispatcher.

Q Tell me, in the higher echelon positions, people most often come in voluntarily? They have never been demoted. They just continue in these positions?

At this point people in those positions we have received knowledge of this information and aside from the Transit Authority. Aside from the Transit Authority knowledge and we have been able to keep them on the

right road.

Q Is a trainmaster an important job?

A I think it is.

Q Are there people who are motormen who have at one time been in your program?

A Yes.

Q Any people who are motormen and are in your program and have never been demoted to a restricted position because of their drinking problem? In other words are there people that are motormen?

A Yes, there are.

Q What is the motivation for someone to continue in your program? Can you state from your experience what the motivation is to stay in your program?

A The threat of job security. When there is a deterioration, the alcoholic becomes very unsure, insecure and he is seeking security. Now perhaps when there is a serious threat to this security, he usually will respond. Sometimes it is not only a job situation. It may be a domestic situation that he will respond to.

Q The job situation is most common?

A Asfar as we are concerned, it is most common. We get them before they get to a certain level. We deal

prevention. They can get back at a certain spot so to speak. And this is the motivating factor.

Q I take it that employment is a very important part of alcoholic rehabilitation?

A Asfar as our company program is concerned, employment, is, but over a period of time, a man must feel the need to adjust. He becomes more or less sick and tired of being sick and tired and sometimes it could be anything that would be the criteria for him to find the need for an adjustment. Sometimes he finds it within himself. Sometimes it is his domestic situation. Sometimes it is a behavior problem outside of the home and we never know what the criteria is going to be. The catalyst that is going to enable him to find the need to adjustment himself.

Q What proportion would you say of the people participating in your program succeed in rehabilitating themselves?

A We are saying 2 out of 3.

Q So that 65, 66 percent?

A Yes.

Q Are there instances where people leave your program and you think that they are successfully rehabilitated and they have a relapse?

A Yes. If your not following the proper prescribed course, you must expect relapses.

Q So, because in the judgment of the Authority, they are capable and then they relapse to drinking?

A It has happened but it very frequently hasn't happened.

Q No sure guarantee?

A I am a alcoholic myself. And there is no sure guarantee for me and I haven't had a drink in 17 years and I can go outside now and pick up a drink.

Q What happens to an alcoholic who hasn't had one in a long time, does he go back into the alcoholic syndrome?

A It does. It is the same as if I had continued to drink for 17 years. It would be the worst type of drinking. I will not return to any kind of social drinking.

Q Does the Transit Authority have a program of routinely screening all employees to see if they are alcoholics, or just when a supervisor sees a problem?

A Are you talking about pre-employment or what?

Q A person applies to the Transit Authority, is he routinely given a test to determine whether he has alcohol in his blood?

A For the moment?

Q Well to

A No he isn't.

Q In a physical exam for promotions in the Transit Authority, are people seeking the promotions automatically tested for alcohol in their blood?

A Not necessarily, no.

Q Are all Transit Authority employees periodically screened regardless of whether they are seeking promotions to determine if they have alcohol in their blood?

A No.

Q We have been provided with a series of documents by your lawyer and a number of these documents summarize seminars that were held at the Transit Authority relating to the problem of alcoholics. I'm referring to Transit Authority exhibit E provided in response to the plaintiff's request over documents. Do these look familiar to you?

A Yes.

Q I take it that these are minutes and summaries of what went on?

A Yes.

Q Do you organize these seminars? It must have been quite a job. Did you select who would speak?

A Yes.

Q How did you decide who would speak?

A Different measures. I have been involved in the alcoholism business for 17 years and I know some outstanding people in the field. The authority's, and I invite them to share their experiences and information with some of our management people to update us and give us a background on what its all about. Most people in the drug field I have heard speak. I have attended many seminars. Visited many drug programs and I have invited some of them to share their experiences with the Authority so we can enhance our information, to update our information.

Q So you just invited leading spokesmen to come?

A Not leading spokesmen. I invited people who I felt would have a message that we would be happy to receive. We are talking about experts I would say in quotes.

Q Was one person William Duncan?

A Yes.

Q And from papers I am looking at I identified earlier, it shows that he spoke at a 2 hour seminar on June 21, 1972. It states that he was assistant director of both labor management services of

the national counsel of alcoholism. Now Mr. Duncan during the course of the seminar, described the different kinds of alcoholic, is that correct?

A Yes.

Q He stated that the social alcoholic is the most common. Do you agree with that?

A Yes, I agree with that. Not the most common but the most obvious, visible alcoholic. He is the one that experiences all of the syndromes like blackout.

Q In the summary it states that they have amnesia blackouts, caused by a malfunction of brain cells. That they have loss of control after drinking. And it also states the compulsive alcoholic, if he has one drink can't predict his behavior. Do you agree with that?

A Yes, and that can be applied to other alcoholics. Before they reach their obvious situation.

Q So then a lot of alcoholics employed by the Transit Authority manifest these symptons if they drink?

A If their alcoholics.

Q People in your program? I take it that there are a lot of people that would manifest the symptons I just read?

A Yes.

Q If someone has been a compulsive alcoholic and takes a drink and he has been in treatment, and he has abstained from drinking for 5 years and he is going to take a drink, would he manifest these same symptoms again?

A Perhaps he would. But he will not come near the job. He would be too sick to come to the job.

Q If he took the drink during his lunch hour, he would be sick on the job?

A Not necessarily. You don't experience those same symptoms by one or two drinks. It takes a period of time to develop into that type of situation and a fellow who has abstained for 5 years, he is not going to come near the job or operate any equipment. I'm quite sure of that. He may become aware of it through some other area other then the job.

Q In his talks, Mr. Duncan also talked about the costs of alcoholism to industry and to employers in general. "There is absenteeism, lateness and poor production." Resulting from poor executive decisions overall. Do you agree with that? That active alcoholics cause those types of problems?

A Yes. The statement that Mr. Duncan made does

not apply to each and every industry. Some industries have a very permissive attitude towards drinking and it becomes a rampant thing. This does not necessarily have to the Transit Authority with very rigid procedures and policies against drinking.

Q The Transit Authority is not one of those?

A No in deed. Perhaps if this was the type of industry where people can have 3 and 4 cans of beer and perform, this can apply in that area. It doesn't have to apply to the Authority.

Q If 3 or 4 cans of beer could cause trouble?

A It could cause a lot of trouble to you and you don't have to be an alcoholic. We never know how one can of beer will effect you. You may be in a poor frame of mind. You may have a disagreement at home. You may not be in the environment that you would like to be.

Q The summary of Mr. Duncan's talk is ", that the rate of absenteeism and hospitalization for respiratory and bone disorders is twice as high for alcoholics then for non-alcoholics resulting in high cost to industry. Has it been your experience that that is true?

A I am not that familiar with that statement.

As I said, I haven't explored it that much.

Q To your knowledge has there ever been a Transit Authority accident caused by alcoholics?

A I have to my knowledge there has not been any serious accidents caused by alcoholics or people under the influence of alcohol or while in operation. Most people will say that alcoholics create 3 times as many accidents as normal. I don't have that experience of the Transit Authority. Any accident or serious accident that we have been involved in in the Authority the first rule of thumb is that they are to be administered a blood alcohol test to determine fitness at the time of the accident and everytime to my knowledge it has been negative.

Q What do you mean by a serious accident?

A Something like on the train or some serious accident.

Q Like a derailment or crash?

A Yes.

Q To your knowledge any instance of operation nor deficiency by alcoholics? Have motormen jumped the signals in the tunnel? Towerman thrown a switch the wrong way?

A Not to my knowledge. Usually, before they are

Q Have you ever seen any safety studies that have been performed regarding the performance of alcoholics in the Transit Authority?

A No.

Q Do you have studies regarding the characteristics of alcoholics as it relates to safety in other industries?

A No, I don't. I have heard facts that absenteeism is higher, but as I say I don't see it in the Authority. Because we have a rigid rule against drinking and the person is not going to come near the job in such condition.

Q Are you aware of any comparative studies like compared in drug addicts to alcoholics?

A No, I don't.

Q You seem very knowledgeable about alcoholism. How long have you been director?

A I have been director approximately 8 years. I have been working approximately 16½ years.

Q Is director of the counseling service the only position you held with the Transit Authority?

A No it isn't.

Q What other position?

A I used to be a railroad clerk. A special inspector. Now I am director.

Q How did you come to be director of the counseling service?

A I was selected. Then I had to take a test to qualify at the civil service program. I came out number one.

Q You said before that you used to be an alcoholic yourself?

A I didn't say that. I said I am.

Q You are an alcoholic?

A Yes.

Q You used to be an active alcoholic?

A Yes.

Q Was that part of the reason you were selected to be director of the service ?

A That is how I entered the program and I was selected to work there with my experience. And I have taken many courses on alcoholism, counseling, and I feel that with this background that I have, my experience working with them, more or less made me capable of performing in this position.

Q From what you just said I take it that during part of your period of your employment with the Transit Authority, you were an active alcoholic yourself?

A Yes, I was.

Q And you yourself participated in the Transit Authority alcoholism program?

A Yes.

Q Was continued employment with the Transit Authority the primary motivation to deal with your problem?

A Yes. The threat of job loss.

How old is the Transit Authority alcoholism program?

A It started in 1956, February 5. It will be 18 years old in February.

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Q That is a long time. Do you know how it came to be established?

A Well from the way I have heard, my predecessor who was a recovered alcoholic, was spending a lot of time talking to people during his working hours and the thought came to him at the time maybe he should start something on a formal basis. When he approached the Authority with that information, they didn't think to highly of it at the time because they felt that we didn't have any alcoholics on the job. Total ignorance at that time. We didn't have any alcoholics they said, plus alcoholics have to have a pretty good medical condition before they come in they must have ability to pass the Civil Service Test, so therefore we don't have that much of a problem and so forth. After a period of about 5 years, something happened and he was given approval to proceed. At the end of six months after evaluation, they would be able to determine whether it was worthwhile. This is heresy. I wasn't around.

MR. SUMMERS: I move to strike that.

BY THE WITNESS:

I came after a year it was operating.

BY MR. BALBER:

A I am a high school graduate. I have taken courses on alcoholism in industry and the Rutgers Summer School of Alcoholic Studies. I have been to Cornell for alcoholism courses. I have taken throughout the City counseling courses in general with the New York City department of personnel. I have also lectured and have been on the faculty of Rutgers Summer School of Alcoholic studies. On the faculty of the Utah State School of Alcoholic Studies. I'm affiliated with the associated labor management consultants on alcoholism. All told, I have perhaps taken about 8 or 9 courses on counseling and alcoholism in general.

Q I just want to confirm something. You took a competitive examination?

A An oral test and exam.

Q You also stated before I believe that you have been affiliated with treatment for a longer period of time then you were with the counseling service?

A Counseling service would be eighteen years in February. My experience is a little over 16½ years. I came up 16 years in August.

Q Where did you have your experience before you entered the counseling service?

A My experience then was through my activities of

participation in Alcoholics Anonymous.

Q Very active?

A Yes. Helping other people gaining insight.

Q Several nights a week? Several times a week?

A Eight meetings a week.

Q Advise people in their homes?

A Yes. Discuss the family situation. Became familiar with all the facilities.

Q I don't understand alcoholism much more than the average person on the street. What is alcoholism? Is it a physical disease or what?

A Everyone that asks for a definition of alcoholism is going to give you a different answer. It is a physical disease coupled with a mental obsession. It is physical and mental and spiritual. We deteriorate in these three areas.

Q Sounds like the total person?

A The total person. In order to recover successfully, we must recover in three different areas. The AA program is geared for recovery of the total man. If we are just going to stop drinking, we become a sober bum. There is no change in personality behavior, attitude, outlook, disposition. We are not really sober.

Just not drinking. So, when we can recover in three areas to any degree, now we feel that we are sober and we are satisfied with what we are doing. We are not doing for anyone else but ourselves. Perhaps when there is a certain reliance upon the physical phase and you have the two areas running rampant, your chance of recovery won't be too successful. Alcoholism is a disease that affects us in just about every important aspect of our lives. Job. Family. Community Center. It first begins to manifest itself in the home. I have yet to meet an alcoholic who did not have family problems. That is where it is first noticeable. Then it is noticeable in his dealings with his associates, etc. The last area is the job area. He tries to hide it from the job. Perhaps when you asked me before about people coming to us voluntarily, perhaps there alcoholism has affected them in the home first and they are trying to prevent it from happening on the job and we will work with them. In our association and dealings with alcoholics, in counseling, we understand that he has a superficial excuse which makes him one of the greatest liars in creation. His values are distorted. He doesn't see himself as another person sees him. So during our counseling, we try to destroy this alibi and excuse and

rationalization and substitute reality which is something that he is afraid of. This is how we treat the total man. He begins to face himself.

Q Is there any such thing as a cured alcoholic?

A I have never heard of it. I haven't had that experience, but I heard recently there is a physician in England who has cured two people and I have serious doubts about that.

Q In other words, alcoholics can always revert to drinking?

A I don't understand the question.

Q I believe you stated before that if alcoholics when out and had a drink, he won't behave like an ordinary man. Somewhere along the line he will lose control. He is more likely to lose control then somebody who has never been an alcoholic?

A Maybe yes, maybe no. Non-alcoholics go out to get drunk as a means of escape. The alcoholic usually does not want to get drunk. It just so happens that it happens to him. In other words, he doesn't have the same freedom of choice as the non-alcoholic. He can't cut off his drinking at any point after he starts to drink. It doesn't have to happen in one day or one week. He can go

for weeks.

Q You described alcoholism as a syndrome that effects the entire person?

A Yes.

Q I take it that simply by not taking any more drinks, the very act of stopping drinking does not rehabilitate the alcoholic? That there is a lot more involved?

A Yes, it does. It's only the start of something.

Q So that when people enter your program which is a program of continued maintenance of soughts?

A Yes. If they are alcoholics it has to be continued maintenance. A lot of them are not alcoholics.

Q But for alcoholics, it has to be continued maintenance?

A Yes.

Q You mentioned before that your success rate is about 60 percent I believe?

A Yes.

Q And by success you meant that these people abstain from alcohol?

A It has not been repeated. There attendance is very improved. No violations on their record and their attitude at the time in our program has improved

tremendously.

Q What happens to the thirty-five percent of the people in your program who are not successful?

A I would say that maybe about twenty percent are still trying to control the drinking. They haven't had a problem in the first place. But they haven't responded too well. They haven't met our qualifications responding. There still drinking and keeping it away from the job perhaps.

Q On the job too?

A I won't say on the job necessarily because we have education for supervisors who do not cover up. They are more or less controlling it on their time and not interfering with Transit business.

Q They don't get dismissed?

A No reason to because they are controlling it to the point where it is not interfering with company business. The other maybe fifteen per cent will invite getting fired for alcoholism or for other reasons.

Q Does that take a long period of time sometimes?

A What is a long period of time?

Q A year or two? Can somebody enter your program and not participate up to standards that you think

are appropriate and stay on the job for a year or two or three years before he is finally terminated?

A Well maybe these people will not meet our qualifications. They will refuse all help but the evidence will prove it is not alcoholism in the first place.

Q What if it is alcoholism?

A It will show up earlier then a year. We are talking about people who do not necessarily drink every-day. We are talking about people who sometimes drink once every six or eight months. That is the only time they feel the urge to drink. They can abstain from it for quite awhile. They have no desire to drink.

Q Their drinking problem while they are employed by the Transit Authority could drag on before they are finally terminated?

A According to what their pattern maybe.

Q You referred to rule 11A before. Is that contained in here?

A Yes.

Q I'm referring to Transit Authority Exhibit B produced in response to the plaintiff's request to the production of documents. Do all people in your program continue on the job with the Transit Authority

in one position or another?

A Some of them will remain on the job. Some of them will get promotions.

Q I don't mean in the same job title.

A Everyone in the program is an employee of the Transit Authority who is working.

Q You said some of them get promoted?

A Yes.

Q Does it happen frequently?

A It happens frequently, yes. There not satisfied with the status quo. They become very productive people. The alcoholic is a perfectionist by nature. He is just not satisfied. His whole potential comes to be when he is sober.

Q Could you list for me some of the titles, some of your participants come from?

MR. SUMMERS: That is repetitious. He went over it already.

THE WITNESS: Just about every title in the Authority really.

BY MR. BALBER:

Q Clerical operational?

A Yes

A Yes.

Q How do you let employees know about your program? Do you post notices or what?

A We do not notify employees. We have had a couple of write ups in the company magazine. We don't find it in the best interests to instruct and notify each and every employee because when a person is involved in alcoholism, sometimes he likes to feel that this is a private matter and he can deal with it in confidence rather then letting everyone in the Authority know. We instruct most of our supervisors, personnel and those other people that carries a message really.

Q You said they are written up somewhere?

A We had a write up in the company magazine, The Transit.

Q When was that write up?

A I don't recall right now.

MR. BALBER: Off the record.

(Whereupon a discussion was held off the record.)

BY MR. BALBER:

Q We were talking about critical jobs versus non critical jobs. What proportion of the jobs in the Transit Authority are classified as critical for the

purpose of alcoholics employment?

MR. SUMMERS: I object to that. Your asking first if jobs are so classified?

MR. BALBER: I didn't ask for an official classification.

BY MR. BALBER:

Q What proportion of jobs of the Transit Authority jobs would fall into critical as you used the term?

A Off hand I would say about sixty percent are critical. This is just off the top of my head.

Q So there are a few thousand jobs that are critical?

A Perhaps.

Q When a participant in your program is demoted from a critical job to a non-critical job, how does he become eligible for the non-critical job?

A For a non-critical job?

Q Right. For example, could a conductor or motorman be demoted to platform conductor? What are the requirements for demotion?

A It is according to what is available. A motorman can be put on platform duty if they have the

position open for him. It is all according to what is available really.

Q Could a motorman become a stenographer?

A No, of course not. It would have to be in his department.

Q To your knowledge can people be demoted to any positions in their department?

A Mostly in the Transit portion, they will put them on a platform. A bus operator may be assigned some duties around the terminal if there is a vacancy.

Q How do you define department as you just used the term?

A There are different areas of operation. We have the transit portion. We have a department that deals with clerks and porters. We have a clerical department. Maintenance department. And so forth.

Q So someone in a critical position would be going into a non-critical position in that department if it was available?

A Perhaps, yes.

Q How many people participate in your program currently?

A Currently, we have approximately I would say about 23-24 people in the program actively now.

Q How many people since you have been director about in the program?

A 4,637 people.

Q When you said 26, did you mean 2600 or what?

A Anywhere from 23-2400 people actively in the program today.

Q Over the last eight years, there have been about 4,637 is that correct?

A Over the last eighteen years.

Q I take it then that some of these people have been in the program a long time?

A Yes.

Q What is the longest period of time that you know of?

A Well there are a few people who have eighteen years of sobriety and they started at the beginning and they are still sober. We have quite a few who have 12 to 15 years of sobriety.

Q Have they been restored to critical positions?

A Yes.

Q But they continued in the program anyway?

A They are not actively involved in the program.

The requirement is that they only follow closely up to a year. These people are involved totally and actively in AA.

Q It is not continued involvement that you would recommend to alcoholics?

A Of course. It has to be a continuation.

Q What happens if there isn't ?

A They are not too successful.

Q A lot of them go back?

A Some of them do.

Q Just a few things. You have used the term critical and non-critical referring to Transit Authority positions. And would you give us some indication of what the elements that enter your opinion that you feel are critical or non-critical? What are the elements that lead you to such a conclusion?

A Anytime a man is in a position where he is a possible threat to the riding public is a critical position. Anytime he is working in a dangerous area where his drinking may be a dangerous situation to his fellow employees, that is also a critical position. I think those would be two major areas.

Q These are the two factors that you take into consideration in determining critical and non-critical positions?

A Yes.

Q You stated that individuals do come to you and tell you in confidence that they have a drinking problem?

A Yes.

Q Is this information kept confidential?

A Yes, it is.

Q How many of the participants in your program would you estimate have been subject to disciplinary proceedings?

A I would say that we have approximately 15 percent of our referrals are voluntary in nature. Plus we may have another three or four percent that are under observation by other people. Maybe perhaps we may get maybe about four percent referred by the union, and this more or less is considered a voluntary procedure and this is confidential.

Q Would it be fair to say that a frequent result of a disciplinary action in which the charge is excessive drinking would be compulsory admission to your program? It would be compulsory?

A But they have the freedom of choice whether they want to pursue the program.

Q If an individual is participating in your program and has a slight relapse, or takes an occasional drink, is he automatically discharged from the program?

A He may just take an occasional drink on his vacation, or he may go overboard on his vacation, or he

may just start drinking on his days off and he may call for help on his days off. We will assist this man and he has still not violated any company rules in that sense.

Q Do you ever discharge people from the program?

A Only when we find out that they are cured and in alcoholism, there is no cure. I am still a participating member of the program. If a man comes to me and he has explored the program thoroughly may be perhaps 5 or 6 months, he understands alcoholism, he will say to me that he understands and says that he has no problems, we will discontinue him from coming into the office because we are not here to manufacture alcoholics. But he has enough intelligence to make that decision. His office visits are discontinued, but we are still following him up through absenteeism, and other information that we get through the Authority as to other violations and such.

Q What about the individual and I am not sure if I have referred to this, who tells you that he has no problems and yet you learn from other sources that this person is condescending?

A I will be a little more firm with him that he

maintain his cooperation with the program through the inside information that I have.

Q And if he persists in his violation, what would you do?

A There is nothing that I can do at that point. As I said, it is involuntary and he more or less has to continue.

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

----------X

CARL A. BEAZER, JOSE R. REYES &
FRANCISCO DIAZ, INDIVIDUALLY & ON
BEHALF OF ALL OTHER SIMILARLY SITUATED,

Plaintiffs,

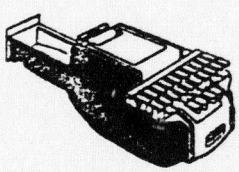
-against-

N.Y.C. TRANSIT AUTHORITY, et al.,

Defendants.

----------X

Examination before trial of the Defendant, N.Y.C. Transit Authority, by Dr. Harold L. Trigg, held at the office of Legal Action Center, 271 Madison Avenue, New York, New York on March 21, 1974, at 2:00 oclock p.m., before a Notary Public of the State of New York.



Ak-Ret Reporting
COURT STENOS

RICHARD S. DOWNEY
RICHARD C. O'CONNELL

16 COURT STREET • BROOKLYN, N.Y. 11241 • TR 5-2442

Q Where do you live, sir?

A 366 West Northview Road, Livingston, New Jersey.

Q What is your principal employment at the current time?

A My principal employment is Chief of the Methadone Maintenance & Service at the Beth Israel Medical Center and Chief of the Drug Addiction Service at Beth Israel Medical Center.

Q Could you describe to us generally the Beth Israel treatment program of which you are Director of? Give us a general idea of the number of clinics and the number of patients.

A You are talking about one of my two major jobs. You are talking about the Methadone Maintenance.

Q That's correct.

A I'll tell you briefly and then you can ask me anything you want.

The Methadone Maintenance Treatment Program began at Beth Israel Medical Center on February 8, 1965. That was the first hospital to have a Methadone Treatment Program. The original research on

Methadone was done primarily in the year 1964 at Rockefeller University. When the research moved out of Rockefeller University on to a service basis, Beth Israel was the first hospital in New York City or anywhere in the world to have a Methadone Maintenance Treatment Program.

Skipping a lot of the in between details, at the present time my primary responsibility is that of the Chief Clinician for thirty-eight clinics located not only in Beth Israel, but in fourteen other hospitals in four of the five Boroughs in New York City. We have nothing in the Bronx. The present patient census is in the neighborhood of 6,400.

Q Did you have a role in setting up the program in 1965?

A Yes, I would like to think I did.

Q Did you have the principal role, would you say?

A I think that Dr. Dole, who is a Professor and Senior physician of Rockefeller University and along with Dr. Mary Nyswander, they did the basic research and when they moved down to Bernstein Institute, which was formerly Manhattan General Hospital, I began collaborating with them very closely

and, in fact, one of my titles at that time was Guest Investigator and Consultant at Rockefeller University, so that I could do part of the research up there with Dole. The three of us worked on a service basis down at Bernstein Institute.

Q Could you describe briefly and generally the treatment used in Beth Israel's Clinic? What the process a participant goes through is?

A Briefly the applicant applies at what we call, "Central Intake" and a history is taken focusing on various things primarily record of arrest and conviction. Certainly entailed drug history. What drugs. Duration of use. Method of ingestion or whatever. Some, of course, are taken by mouth and some others by nose. A brief family history and certain other details. If the patient has a Medicade Card, financial status and so forth and history of previous psychiatric treatment or hospitalization to rule out a major or mental disorder. If patient passes that part he is then given a complete medical history, a complete laboratory work-up.

If he passes that part, he is provisionally accepted for the Methadone Program and is given a date

to report to the doctor in charge of one of our clinics. It's the doctor in charge of the clinic who makes the final judgment as to whether or not the patient is suitable for Methadone Maintenance.

If the decision is in the affirmative and it usually is these days, 90 percent of the people who apply are accepted, a Methadone Escalation table schedule is set up. It takes about four weeks to get the patient up to a maintenance dose of methadone.

Now, after that four weeks when the patient is up to the maintenance dose of methadone then just about anything you can imagine might happen in terms of rehabilitation depending upon what the current status of the patient's life is like.

For example, some patients come to us already employed so there is no point to send him to vocational rehabilitation work unless the patient is unhappy with the kind of employment and wants to switch jobs. Some patients have no place to live so we have to find them houses. Some have no jobs and we have to find them jobs.

That is a very complicated process but it might be easier to cover it by saying in our clinics the discipline represneted are psychiatry, internal

medicine, family therapy, vocational education rehabilitation, individual counseling, group counseling, marital counseling. I don't remember if I said social service and after that, of course, it is a matter of how fast a patient moves as to whether or not he is rehabilitated.

The main ways that we measure rehabilitation are three. That is freedom of arrest. Not just convictions because, as you know, there is ways of getting arrested and not getting convictions. Other substance abuse, other drug abuse. We don't count methadone, of course, and the third major point in rehabilitation is whether or not the patient is working or going to school or both or the patient may be a homemaker, which used to apply essentially to females, but this is 1974, so homemakers can also be males and the woman can be out working.

Q Would the medical specialties that you listed, Dr. Trigg, be indicative of what you would characterize as other components of methadone treatment, when no part of it is the ingestion of methadone, is it fair to say that these other specialties comprise other vital components of the

overall program?

A Certainly to me, they do. The other disciplines that I mentioned represent essential components of the Methadone Program because after a certain "X" number of weeks, a couple of months, there are individual variations. The ingestion of methadone for the patient usually becomes a very mechanical thing as much as let's say drinking a cup of coffee or drinking a glass of orange juice and the preoccupation usually ceases, I would say, for most patients by the end of the third month of the Program and it is usually around the third month that the patient begins to express an interest in other aspects of his life not related directly to drugs such as employment or getting back with his family, better housing, getting out of the junky neighborhood.

Q You would say that the three-month figure is a general figure for when a person would be medically stabilized?

A Yes.

Q You refer to these as components of the treatment program. Is it not true that some of these, I'm sure Beth Israel is far beyond the

minimum standard or mandate by the Federal & State Regulations, so that every certified Methadone Program would have a counseling component?

A As I recall, the Federal Regulations which went into effect May 15th or March 15, 1973, yes. Those are minimum requirements. It was a rather late coming. We had the components that I mentioned essentially all in the programs by 1966.

Q You mentioned one of the indicia rehabilitation or professional success to be no use of elicit drugs?

A That's right.

Q Would it be correct to say that no person would be deemed a satisfactory participant in your program if he were found to be using any elicit drugs?

A Any elicit drugs other than methadone, which we couldn't care less, speaking from our Program. We don't care about pot smoking.

Q Do you at times discover participants who are using elicit drugs?

A Yes.

Q What is done about that?

A Well, that's not an easy question.

Q Would it be fair to characterize your remarks prior to this as generally saying that there is indeed such a person as a rehabilitated drug abuser, that it is possible to rehabilitate oneself from drug abuse?

A Yes.

BY MR. MORRIL:

Q Dr. Trigg, you referred to several consulting relations. To whom do you serve as a consultant at the current time?

A The Veterans Administration Hospital, 24th Street and Third Avenue and the Veterans Administration Regional Office at 252 Seventh Avenue. The New York City Board of Education. The Medical Director's Office and the New York City Transit Authority. The Special Action Office for Drug Abuse Prevention, The White House, Washington. I think those essentially are the current ones. I don't recollect any more.

Q Dr. Trigg, what do you do as a consultant for the TransitAuthority?

A As a consultant to the Transit Authority I examine employees referred to me by the Transit Authority for an opinion as to whether or not such and such an employee is currently abusing substances with a high abuse potential or has in the past abused substances with a high abuse portential. I'm using the word "abuse" to cover use and addiction

Q Do you see employees only, Dr. Trigg, or do you see job applicants as well?

A I need some clarification on that so that I don't mislead you. I don't only see people who are currently employed but I also see people who have passed the examination and are ready for appointment but have not been appointed yet, if you are calling them applicants.

Q Yes.

A I do see some of them, too.

Q Dr. Trigg, would you describe the examination that you performed on people referred to you by the Transit Authority?

A The examination consists of a section called "History" under which I state the subject was referred to me by the New York City Transit Authority. I get his age, race, sex and a statement as to whether or not the applicant knows why he has been sent to me for examination and a statement from the subject which is indirect response to a question from me: "Have you ever used drugs?" And then I give him a list of drugs. "Was that past history or are you currently using" and then I put his response in quotations. That is essentially the history.

The second part of my examination is a physical examination which is remarkably circumscribed. One section consists of observation of the completely nude body, exterior skin, total body under a magnifying glass and high intensity lighting looking for areas of new punctures, tatoos, or in the venacular tracks in the skin. The second part of my circumscribed examination consists of an examination of the pupils with an opthalmology scope in which I look for the size of the pupils, whether they are equal or unequal, the degree of dilation or constriction or whether or not the pupils

react to light and do they over react or are they cluggy to light or do they react normally to light.

The third part of my examination consists of an examination of the nasal mucosa, looking for the degree of reness or pallor and for any areas of ulceration of the flushy mucus membrane or the structure of the nasal structure which separates the two sides of it. That's my physical examination in this context.

The final part of my examination is a heading called "Clinical Impression," never diagnosis, and I want to be clear on that. Never a firm conclusion but "Clinical Impression," as to my opinion in my carefully professional opinion there is or isn't sufficient evidence on which to base an impression of drug abuse past or present.

Q Is it fair to say that your sole judgement is whethere there is sifficient evidence to establish that a person has been past or present a drug abuser, is or has been a drug abuser?

A That's my sold judgment.

Q Do you make any judgment as to the applicability of the patient?

A I do not.

Dr. Trigg, what are you looking for in your examination of people referred to you by the Transit Authority?

THE WITNESS: I have to go back to what I described that I do which would be an indication to me of what I'm looking for. For example, in the section that I described as "History", if I ask an individual if he is currently using drugs and he answers yes to the question, heroin

then that would be one thing I am looking for.

Q What are the signs for drug abuse for which you look during an examination, Dr. Trigg?

MR. TAYLOR: Well, I think it is already answered but he may answer.

THE WITNESS: Again I just want to go over that part about history taking. That is always important in medicine and in trying to come to a conclusion about any disease. In terms of the physical examination part the purpose

of the close observation of the external skin is to look for any areas that would show pathology that would be consistent with certain forms of drug abuse For example, a set of track here at the antecubitalfossa, those would be pretty good diagnostic or puncture marks. Let's say the big muscle up here on the arm, the deltoid. If I saw repeated needle punctures there that would confirm any suspicion that I might have.

In examining the eyes I'm looking primarily for excessive small pupils because individuals who have recently, and by recently I mean probably within three or four hours taken a good shot of heroin, have what they call pin point pupils because they are so small they look like a pin point. Now, the absence of a pin point pupil does not mean that the individual

has not used any heroin. It may mean he has not used any recently or never had used any. Now, the point in looking at the nasal mucosa is a little more delicate because of the degree of pollutants in the air in a highly industrialized area and an excessively redened mucosa does not have the same significance as it does on an individual who breathes fresh air. The ulcers, if they are found, could be highly subjected of snorting of cocaine. The urine reports are sent by the Transit Authority and there again I have to make judgment based on my own assessment of what urine reports mean.

Q Do you discuss the reports that you make with anybody at the Transit Authority?

A The answer is no. I do send a report to the Transit Authority and that's it.

Q Do you communicate your findings to

the person you have examined?

A No.

Q Do you ever recommend to the Transit Authority that a person should be employed but with certain limitations on his employment?

A I do not.

Q Is it a fact that you discussed the Transit Authority policy with regard to employment or retention in employment of people with drug

abuse histories with various people in the employ of the Transit Authority; is that a fact?

A No.

Q You have never?

MR. TAYLOR: He has answered it.

Q Have you ever discussed drug policies with anybody in the Transit Authority?

A The answer is no.

Q Dr. Trigg, did you participate in the Transit Authority policy with respect to the employment or retention in employment of persons with a history of drug abuse?

A The answer is no, and I would like to -- I hope

I'm not overstepping anybody. My arrangement with the Transit Authority is to do a specialized medical examination and give a clinical impression and that's it. That's the extent of my responsibility as a consultant.

Q Have you ever participated in any review of the Transit Authority policy?

A No.

Q Have you ever participated in a review of the Transit Authority laboratory procedures?

MR. TAYLOR: I object to it unless it is confined and related to drug abuse.

MR. MORRIL: I direct the witness to answer the question.

MR. TAYLOR: I instruct him not to answer.

MR. MORRIL: Have you ever participated in a review of the Transit Authority's policy with respect to drug abuse?

THE WITNESS: My answer to that would involve some remarks which would have been answered to previous questions of yours which my attorney instructed me not to answer.

MR. TAYLOR: May I have the question read again?

MR. MORRIL: Read back the question, Mr. Reporter.

MR. TAYLOR: You may answer that.

THE WITNESS: I think I have. I think that my answer to that would have to be, yes, if I understand what you mean by "review".

MR. DUNN: I move that the answer be stricken as unresponsive and if the witness understands the question there will be no objection to the answer. If counsel will like to rephrase the question --

THE WITNESS: I'm having difficulty with the word "review".

BY MR. MORRIL:

Q Have you ever considered the contents, the substance of the Transit Authority policy?

MR. TAYLOR: I object to it. Please don't answer that.

Q Have you ever been asked to consider it?

MR. TAYLOR: I object unless the answer is yes or no.

MR. MORRIL: It seems like a yes,

no question to me.

THE WITNESS: I find it very difficult in this very delicate area to say yes or no to just about anything except questions about my correct age and name and things like that.

(Continued)

Tape 4-1

Q Dr. Trigg, I'm very sympathetic to your position. I just want to remind you that you are under oath and the questions we are asking you are proper and relevant.

A On one occasion I was asked by the Transit Authority to visit their Medical Department and observe the steps through which employees know when they are given physical examinations. I saw the complete set up and that is why I was having difficulty answering your question of, "Have I ever participated in a review"? A review to me can be sitting down in a top level meeting looking at top level policies and being asked for comment on that. That type of review, no. The actual physical setup, method of urine collection. The bottles in which the urine is collected. How long it is stored. The method of transport to the laboratory. The method of analysis, urine analysis used by the particular laboratory. Yes, I have reviewed that.

Q Dr. Trigg, have you ever discussed with anybody in the Transit Authority whether persons who are rehabilitated drug abusers, as you define it, could be employed by the Transit Authority?

A Yes.

Q With whom have you discussed that?

A With Mr. McClaren, with Dr. Lanzetta. After that I would be just guessing.

Q On what occasion did you have this discussion, Dr. Trigg?

A This initial big meeting that I referred to, I don't think it came up there. It was at a much more informal sort of thing. It could have been even over the telephone in which I brought up the matter of employing rehabilitated drug addicts and the discussions were quite brief.

Q Could you describe the substance of the discussions?

A My recollection is essentially two instances where I brought up the possibility of hiring rehabilitated former addicts but I was given the

impression that the Transit Authority did not want to tackle those issues with me at that time. There was no implication that they had no interest in such issues but that other problems needed to be ironed out first because they were more pressing. Exactly what other problems, I do not know and I did not press the issue.

Q When did these conversations take place, Dr. Trigg?

A I would say well over eight years ago. I

Q Does that refresh your recollection as to the conversation?

A Yes, and I do believe that I misled you and apologize. It was not intentional. Let me be a little more specific. The issues which I raised were not in the context of the Transit Authority's overall policy of retaining in employment uncovered cases of rehabilitated drug abusers, drug users. It was like, "What are you going to do in the future" because this issue is going to be raised specifically about Methadone patients. It wasn't even about rehabilitated drug abusers, let's say, from a theraputic community because my focus is mostly on Methadone Maintenance. The issue that I raised was specifically about hiring rehabilitated Methadone maintenance patients and now I remember another part

of the brief discussion was that it's very difficult to determine or come to any standards that could be agreed upon as to what constitutes a successfully rehabilitated methadone patient working for the Transit Authority where thousands of the public lives may be at stake. But I have never had a discussion with anybody in the Transit Authority about what they do when they uncover a case of a drug abuser who's currently in their employ. I don't know whether they terminate him or move him into a less sensitive slot or what. I never discussed that with the Transit Authority.

So, my discussion, the point I was driving home to them or attempting to, was much more focused than I gave you to believe in my original testimony.

Q Thank you. Dr. Trigg, is it possible to make a physical determination on the basis of any physical examination that a person is no longer a drug user but was at onetime a drug user, drug abuser, I should say?

A The answer to your question is yes, but medically, I would like to qualify it and say that it is very difficult to make a determination of drug addiction if the person being questioned is saying admittently, "No," unless he has a pretty diagnositic set of tracks in his arm, but if an individual, let's say, is snorting heroin everyday it is very difficult to reach a positive determination that he is snorting heroin everyday unless you picked it up in his urine on repeated urine analysis. It is a difficult thing to come to, that is why in my medical reports to the Transit Authority I never

5-1] use the word, "Diagnosis." I always use the word, "Clinical impression."

Q Is it possible to determine that a person is not a drug abuser?

MR. TAYLOR: You are continuing your thought by physical examination; is that correct?

MR. MORRIL: By physical examination plus history or whatever the patient may say.

THE WITNESS: Let me put it this way. This is an area of medicine in which a positive finding can mean a great deal. On the other hand to make it tricky the absence of the positive finding does not rule out the existence of the condition.

Q In any person; is that correct? If you were to examine me, Dr. Trigg, could you say 100 percent that I'm not a heroin addict?

A No, not 100 percent. I can't say 100 percent to anything in my field.

Q Doctor, again I want to refer to the conversations you had with Mr. McClaren and

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Dr. Lanzetta in which you said you brought up the subject or the possibility of the Transit Authority at sometime perhaps in the future hiring persons with drug abuse histories. When you say, "Brought up," did you recommend that they do so?

A No, I didn't recommend. It was more or less, I guess, if I can speak informally, it was a needling sort of question on my part like; "Hey, when are you going to start hiring some of my Methadone patients?" In that context. " I got some pretty goods guys who I think can do some pretty good work for you and I would like to see them get a job for you." It was more that sort of thing. It was not rehabilitated addicts in general. It was patients of mine primarily. I was being very selfish. I would pick them and screen them and I would back them up.

I think we mentioned we would come to some sort of agreement that I would get a written consent from the patient, prior to his employment with the Transit Authority, that if he started abusing other drugs that I would have every right to notify the Transit Authority that that was going on because I certainly don't want any bad public relations with

5-13 employers regarding my patients. That won't set a good example. I don't know if it was Mr. McClaren or Dr. Lanzetta but their response was something like, "That is a good point and we ought to keep it in mind for subsequent discussions."

Is part of your role as consultant with the Transit Authority to make the determination of whether a person is a former drug abuser?

A Yes.

Q What are the signs which would lead you to believe that a person has been in the past a drug abuser?

A I think I answered that before but I will do it again. I gave a complete answer in the previous deposition, and I also answered it for Judge Griesa.

The problem in assessing past drug abuse hardly differs from assessing present drug abuse.

Q Hardly differs or highly differs, doctor?

A Hardly, except for the presence in the part of an examination which I described in which a history is taken of the patient and then a very circumscribed physical examination is performed where I look at the skin.

Now, on past drug abuses, in terms of looking at the skin, I would not expect to see fresh needle marks on a former drug abuser. In the terms of the pupils of the eye I can't make anything out of that because I testified in my deposition before this one that if the pupils of the eye are very, very small, if they are pinned, that would indicate recent drug abuse, but that pinning effect wears off in two to four hours after the last injection of heroin, depending upon the strength of the heroin.

So, the individual could have taken heroin five or six hours before I examine him and I would not be able to make anything out of the eyes or the pupils.

On previous testimony I told you

about this trick nature of checking the nostrils because of the pollutants in the air. I find it very difficult for me to do anything with that. As a matter of fact, short of the history from the employee or subject or patient, in which he might elicit that he used drugs in the past, it is very difficult to tell, and, of course, practically nobody is going to answer that question truthfully. But, I really have to be very careful in assessing whether the patient, or for that matter, a friend, was a past drug abuser.

Just to throw a little bit more light on this, let's say that I am able to determine from looking at the age of the track marks that the individual did in the past use heroin. Now, he still could be using it but he could be snorting it. I can't depend on looking at the skin, I would have to depend on the nasal mucosa, and that finding is complicated by the pollutants in the air.

Q Is it possible to determine with any degree of certainty that a person was using drugs in the past?

A That's a tough question, because when--

you say "using," there are various routes that can be used. For example, it could be snorted, an individual could have been snorting heroin for ten years and stopped three years ago and may never have injected himself with heroin. Therefore, he would never have developed a set of tracks, and I can't tell by looking at his nose three years later as to whether or not he snorted heroin back ten years ago.

Q Is it possible to distinguish the age of track marks?

A There again I want to be careful. Yes, I can tell you,within broad limits I can tell you, but I can't tell you which ones are two or three or four months old, but I can tell you which ones are seven days old or which ones are more than two years old. For example, I certainly can recognize those that are maybe two or three days old because there is probably still a small globule of fresh blood,a blood clot there under the skin, but in an old one, I don't think anybody could tell you the age, short of an anatomical section of the skin being put under a microscope. As I said, with track marks

it might possibly be four years or six years old. There is no way to do that by a visual inspection.

Q Can you give us a rough idea of point in time at which it becomes impossible to discover the age of the track marks? In other words, are you saying you cannot tell if it is four or six years old? Could you elaborate more on that? In other words, is it possible to tell if the track marks are eight months old as opposed to two years old?

A I can't, I can't.

Q What would be the cutoff point?

A I really don't know but I think the cutoff point for me on just a visual inspection would probably be in terms of days rather than months.

Q After a few days it would be indistinguishable?

A Yes, maybe after ten, twelve, after four teen days, but right now I'm just speaking for myself.

Q How do you, with such an individual, make a determination whether a person is a former drug abuser?

A Well, if the tracks are old, and I can't say that they're less than a month or two months old, but I can say that the supravenos findings would be consistent with the findings of a drug abuser.

I might add that it is not possible for me to determine within the realm of reasonable medical certainty whether an individual is currently abusing drugs, especially since, in most cases, the individual would deny the current use of drugs, and he can also deny the past use of drugs. And if he denies the past use of drugs and he has some track marks, to me, that would indicate to me that the medical opinion that I have is contrary to the patient's history, but I am very careful of giving that; that's why I am going to repeat now that I made a clinical impression rather than diagnosis.

Q Do you consistently report to the Transit Authority when you examine an individual whose only sign of drug abuse are track marks, which are indistinguishable and, let's say, more than a month old? Do you consistently report to the Transit Authority if such an individual has

signs of former drug abuse and where it is impossible to tell whether he is a current drug abuser?

A Well, the word "consistent," makes it hard for me to answer that question. Now, are you asking me if I consistently reported that if I saw a set of tracks that were highly suggestive of drug abuse in the past, are you asking me if I reported that?

Q Yes.

A Yes, I would always report that.

Q Could you tell us what you found out on April 3rd, 1974?

A Well, I received a brief, a part of a brief prepared by your staff, and on Page 3 Mr. McClaren seems fairly clear. I remember this very well, because it was-- because I was relatively impressed with what they were doing with my report, but I did not have any discussion before that, and I would think that it would be highly improper for a consultant to badger somebody to ask them what they were doing with my reports, because my reports were simply advising them on what they were asking me to do, and I was making an assessment as to hard drug abuse in the past or present, that's all.

Q May I see that, please, doctor?

Q Dr. Trigg, you seem to have indicated

a considerable amount of surprise when you read that portion of Mr. McClaren's testimony. Since you read it, have you called anybody in the Transit Authority or have you discussed this case with the Transit Authority since you found out about this information on April 3rd?

A No, I did not,but you are using the term "surprise," and I would rather, or I would prefer to use the term "reassured."

Q Did you know of any reason why they should not hire methadone patients in some capacity?

A I can't answer the way you phrase it. It should be some methadone patients in some capacity, not methadone patients in general.

(Discussion off the record)

Q Did you know of any reason why some methadone patients should not be hired in some capacity by the Transit Authority?

A Obviously,we are not talking about 100 per cent of the methadone patients to be employed by the Transit Authority. There are some methadone patients which I would not consider employable.

Q Well, would you be talking then about patients that are primarily stabilizied?

A Yes. I would not be talking about patients who would be using other drugs or have very serious problems, I would not send them out on any kind of job.

Q Did you tell Dr. Lanzetta and Mr. McClaren that you believe that some methadone patients were employable in some positions in the Transit Authority?

A Did I use those words?

A Perhaps not those words but the substance of those words, did you?

A Sure.

In asking that question: "When are you going to employ some of my patients," it would be difficult for them to escape the implications that I was making unless I was just plain joking; and I was not.

Q Did you tell them why you felt that they would be qualified for some Transit Authority employment?

A I don't think it ever got that far as to why.

Q Did they tell you if they had ever considered the problem prior?

A No, they did not say that they had considered the problem and they did not say that they had not considered the problem. They just said or replied that there were more pressing things and we did not get into that. And they said that it was an interesting area to pursue at some later time. So they really did not drop it completely.

Q Were there any studies or reports that you read at any time that influenced you in making the suggestion to Dr. Lanzetta in reference to hiring of your methadone patients?

A Studies or reports that I have read that influenced me?

Q Or anything in your experience, doctor?

A Well, that makes it clearer, when you say anything in my experience. The answer would be yes, in my experience, but I do not know about

reading any specific thing in regard to that suggestion, but from my day-to-day clinical observations and experience, I would say yes.

Q Doctor Trigg, I believe you said, in Judge Griesa's chambers, with respect to these informal conversations that you had that you mentioned, that it would be more palatable to the Transit Authority, and that you would be willing to cooperate in the screening or monitoring of the employees for the Transit Authority who were enrolled in such a program?

A Yes.

MR. SUMMERS: May I see that where he made such a statement?

MR. MORRIL: It may have been off the record. I think the doctor can recall saying that.

Do you, doctor?

THE WITNESS: I did. I did say that. I think it might be in the session of the previous deposition, the last deposition that was taken of me.

Q Could you describe that portion of the conversation, please?

A Well, that was a very brief conversation that I had, and I even said that I would go as far as getting a consent for release of information from my patients and that I would tell the Transit Authority if he abused any other substances or abused other drugs, and I have given previous testimony to that effect.

Q Did you mean by "positive movement," did you mean by that with respect to their problems that you had hoped that the Transit Authority would start to hire persons that were methadone patients, some methadone patients in some capacity?

A I don't think I meant anything that specific. I was recalling silently to myself, and I will say that I was not saying this before Commissioner Norton, but I was thinking about the time that I testified against the Transit Authority, and I felt that the Transit Authority had made substantial progress for what I believe to be, was there position just not discharging employees for one positive quinine, and I believe that the Transit Authority was not doing it because of this case in which I testified against them, the employee was discharged on the grounds,which to me were not medically sound, which I told you previously I had testified against them, and then later on the Transit Authority approached me to become their consultant. And based upon my testimony against them, they would be a bunch of idiots to hire me, because they certainly knew, and they had no reason to believe that I could be bought for $175 an hour. So they knew

what they were getting when they asked me to become a consultant.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
- - - - - - - - - - - - - - - - - - -x

CARL A. BEAZER, JOSE R. REYES and FRANCISCO DIAZ, individually and on behalf of all others similarly situated :

Plaintiffs :

-against- : 72 Civ. 5307

NEW YORK CITY TRANSIT AUTHORITY, et al :

Defendants :

- - - - - - - - - - - - - - - - - - -x

Deposition of William J. Ronan before a Notary Public of the State of New York held at One World Trade Center, New York City, on Wednesday, June 5, 1974, at 9:50 a.m.

APPEARANCES:

JOHN G. deROOS, General Counsel
EDWARD W. SUMMERS, Esq.
For the New York City Transit Authority

ERIC D. BALBER, Esq.
MARK MORRIL, Esq.
Legal Action Center of the City of New York

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Harry Weiner
CSR

year.

Q Are you familiar with the policy in effect at the New York City Transit Authority and MaBSTOA or were you while you were Chairman and Chief Executive Officer regarding appointments of persons with histories of drug addiction?

A Yes. There was a rule which had been standing since the early 1950's, and there was a rule in the predecessor agency or agencies which related to the employment of people who were drug addicts.

Q You have previously submitted answers to interrogatories that were served by the Plaintiffs in this lawsuit?

A Yes.

Q And in Response Number 1 to the interrogatory you stated in part: "The long established policy of the Transit Authority and its subsidiary, the Manhattan and Bronx Surface Transit Operating Authority, not to employ or retain in their employ persons--

who are or have been addicted to hercin, notwithstanding their present or past participation in a methadone maintenance program..." Then you go on to state whether this policy has been reconsidered at any Board meeting of the Authority. Is that clause accurately stated?

A That is accurately stated.

Q It states the policy of the Authority?

[illegible] but I think it also quoted the

Q Were any of the man failures that resulted [illegible] that you just referred to the result of drug abuse or methadone?

A These particular accidents, there was no evidence at the time that these were related. These were accidents which resulted in passenger fatality at the time, but there was no evidence produced at the time. Nobody would assume that.

Q Any evidence produced subsequently?

A Or subsequently.

Q Was the drug policy, was the employment policy respecting persons with addiction history ever reviewed by you as part of any internal review, procedure or general personnel policy?

A In terms of an overall review of personnel policy, we accepted the existing personnel policies which seemed to be satisfactory, and there was no major overhaul of the personnel policy during the time that I was there.

Q I believe that you stated earlier that at those times that you did consider whether the policy should be continued, you consulted with persons from among your cadre of Executive Officers.

A Actually, it was not a question of whether we thought

the policy should or should not be continued. That was never discussed. It was the question of implementation of the existing policy. I would not want to give you the impression that there has been a discussion as to any recommended change in the policy. I recall no such discussion of anyone or anyone suggesting to me as the Chairman and Chief Executive Officer, either from the Board level or the Executive level--I recall no one having raised the question that we should change the policy. Discussions were in terms of the implementation of the policy, as I recall.

Q What aspects of the implementation were discussed?

A Among others, I think the medical examination procedures, as I recall.

Q Urine analysis?

A Yes. Actually, I think it was in the context of the adequacy of some of the tests to detect narcotic addiction. I emphasize there is very real concern on the part of anyone who runs a transit system because of the lives at stake all the time in any failure on the part of an employee, and the lapse which would cause death or injury to the traveling public, or, for that matter, even extensive delays, inconvenience and other suffering. So that one is deeply concerned about the adequacy of protective procedures, and not just mechanical ones but all those

that relate in terms of personnel. One has the problem of almost inexplicable lapses of times on the part of employees.

It is our understanding, and it is our understanding from the statement, that the policy of the Transit Authority while you were there was not to employ persons who were addicted to drugs or had been addicted to drugs.

A That was a long standing policy continued, yes.

Q Present as well as past?

A Yes.

Q What specific persons from among your Executive Officers or any other personnel, did you consult with concerning the drug policy, its implementation?

A Well, in terms of discussion of the implementation of the policy, I discussed it with the Executive Officer in charge of Personnel and Labor Relations, Mr. Wilbur McLaren; I discussed it with Mr. Daniel Scannell, who is the Senior Executive Officer in charge of Operations and Maintenance, with Frank Berry who is the Executive Officer in charge of the Rapid Transit Operation. Those would be the principal people I discussed it with, legal counsel as well, and I think I probably discussed it with Mr.

Sidney Brandes, who was with the Transit Authority in the position of Counsel before Mr. deRoos came on board. Those would have been the principal people. Any others would have been, I think, rather incidental.

Q Have you ever spoken with any persons involved in the field of drug treatment regarding the Transit Authority policy?

A Well, I would amend my earlier statement. I did talk with Dr. Lanzetta, too, who is the principal Medical Officer. If he were involved in any way in the analysis, I would have talked with him. I have not talked with persons actually in the therapeutic area vis-a-vis the policy of the Authority, not to my knowledge. The occasion never arose.

Q Did you ever examine any scientific studies or other written literature that might be relevant to the necessity of continuing the Transit Authority policy?

A I would not say that I did. It depends on how you define "scientific literature."

Q Any literature.

A I was aware of the controversy within the medical profession itself, the scientific profession, vis-a-vis the whole matter of drug addiction and drug therapy, and the wide differences of opinion that appeared to exist among people who were in the field.

Q How did you become aware of these?

A Just normal reading in the newspapers, magazines, professional journals, and the like.

Q What types of professional journals?

A It is the kind of thing that one picks up, I suppose, things like the Scientific American--would that be a professional journal? That type of thing. I am not a reader of medical or professional journals. I would not want to give you that impression.

Q Have you ever examined any psychological studies or anything?

A Not as such, no. My reading is, I would say, generalized.

Q Are you familiar with the alcoholism program that was in effect at the Transit Authority?

A Yes.

Q That is, at the time you were there?

A Yes, generally familiar with it.

Q In order to save a little bit of time, Mr. McLaren has previously testified, and I will try to summarize generally his testimony. He has testified that under that program persons who are found in violation of Transit Authority rules in that they took alcoholic beverages while on the job, if they are in

non-critical positions they are summoned before a departmental hearing in the initial stages and allowed to participate in the Transit Authority's alcoholism program, remain at their positions. If they are in a critical position and have three years of accumulated seniority, they are allowed to accept a demoted position to a non-critical area--at least in the initial stages--and charges against them are open. They are allowed to participate in the Transit Authority's alcoholism program. Is that your understanding of it?

A I think that describes it.

Q And you never took steps to change or even review the alcoholism program?

A No, that isn't quite true. I never systematically in terms of a wholesale review of the alcoholism program became familiar with it. There was no particular reason indicated to have what I might call a comprehensive wholesale review.

Q What facts existed that indicated that such a wholesale review was not warranted?

A That was not the juxtaposition of the situation at all. It wasn't a question of what facts existed to not justify an inquiry. There was nothing adduced that indicated that the program

was unsuccessful. I don't recall quite at the moment what the sources were, but from several sources there were commendations of the alcoholism program from some outside sources. I don't recall now what they were. Some back a number of years. It was considered to be one of the more effective industrial programs at the time.

Q You had then no reasons to conclude that the program endangered the riding public?

A No. It appeared that the program was a fairly effective one. As I say, I have forgotten what the outside sources were that commended it, but it was not only the internal judgment of the people working here, but also on the outside.

Q If it did endanger the riding public, would that factor come to your attention?

MR. SUMMERS: I object to these hypothetical if questions. I think hypothetical questions are outside the scope of the examination.

MR. BALBER: It is a hypothetical question with sufficient concreteness, I believe, to be answered by the witness.

Q In the normal and usual procedures that existed at the Transit Authority while you were Chairman, and the types of things that were brought to your attention in your capacity as

Chairman, if a program, if a personnel policy like the alcoholism program was endangering the riding public, would that have come to your attention over the years that you served as Transit Authority Chairman?

A Well, let's look at it. If there had been failures in the system which had in any way, shape or form endangered the traveling public and they could be traced back to an inadequacy in our program in the Transit Authority, it probably would have been brought to my attention in a very vigorous way. There were elements where this was the case where a long standing rule allowed a motorman on a train to go by a red signal to what is called a key-by procedure. This had existed for many, many years. The key-by procedures resulted in an accident or was a contributing element to a major accident in the subway system, and as a result of that we did inquire into the whole operation of this rule. It was an incident, and we changed the rule. We had no such incident develop in conjunction with the alcoholism program at all.

Q So then you never had a system failure--

A That was traceable to a failure in the alcoholism program, no.

Q Dr. Ronan, methadone maintenance is a relatively recent treatment modality, are you acquainted with that?

A I am generally acquainted with the fact that there is a methadone program. I am further acquainted with the fact that it seems to be a controversial program. There seems to be a difference of opinion among experts, at least self-styled experts, as to the efectiveness of methadone and whether it does or does not cure addiction or whether it continues addiction and what the impact of it is, and all the rest of it.

Q Methadone maintenance on a large scale in New York City's area was instituted while you served as Chairman of the New York City Transit Authority, is that correct?

A I don't mark the date particularly. I know it was in existence at the time.

Q Was there ever any discussion between you and any other Transit Authority executive officer or personnel regarding whether methadone maintenance should be accepted for the overall drug policy?

A It never really came up. Again, I go back to our earlier questions. The discussion was with the executive cadre of the Transit Authority. It was related really to implementation of our existing policy. I don't recall any discussion of a revision of that policy to substitute the kind of policy you are talking about.

Q You referred earlier to some accident that occurred

while you were Chairman of the Board.

A Yes.

Q Due to man failure?

A Right. That was the conclusion of the investigatory bodies that that was the case.

Q Were those investigatory bodies grand juries?

A There were a number of investigations, some by a committee of our own Board. In some instances it was a District Attorney's inquiry. I don't recall the grand jury investigation per se, any presentment following it, but the District Attorneys in Queens and in Brooklyn did make inquiries. What they submitted to the grand jury, if anything, I don't know.

Q Are you familiar generally with the results of those inquiries, the findings?

A Well, to the extent that there were any, with all of those that were done by the Authority's committee itself--in one case it was done by an international group which I asked to come in and survey the safety of the New York City subway system--with all of those I am considerably familiar. As to a District Attorney's inquiry, unless we were privy to a communication from the District Attorney which is a public document I would not have been.

Q Did any of these investigatory bodies conclude that

safety failures or accidents in the Authority had been the result of Transit Authority employees using drugs?

A No. It was indicated earlier in these cases that there was no implication, as I recall it, of any drug-taking by the individual involved in the accident nor alcoholism for that matter.

Q Drug-taking, including methadone maintenance?

A It never arose. There is no imputation that there had been drug-taking.

Q Is the public image of the Transit Authority one of the bases for the continued maintenance of the Transit Authority drug policy?

A The policy has been maintained because there was never any real move to question it, and, actually, it is part of a total policy to try to continually minimize the chance of anything going askew that will cause an accident, which would imperil the riding public. The transit business is constantly concerned with reducing the chances of accidents, and when you carry seven times the population of the United States of America in one year, and I think that is the figure, it is a very awesome responsibility, and safety is a matter of continually reducing risks and, therefore, one of our concerns always is to reduce the area of risk. One attempts to reduce this in terms of

mechanical and electrical, in terms of personnel policies, procedures, rules and the like, and the fact that the New York City subway system is the safest rail system in the world of any comparable size, I think is a testament to the fact that the mechanical, electrical and personnel measures that have been taken are basically the factor. I for one would not like to see a loosening of these regulations which would open the door to the possibility of fatal accidents or accidents involving injury occurring. It is a very serious proposition.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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CARL A. BEAZER, JOSE R. REYES and FRANCISCO DIAZ, individually and on behalf of all others similarly situated :

Plaintiffs :

-against- 72 Civil 5307 :

NEW YORK CITY TRANSIT AUTHORITY, et al :

Defendants :

- x

Deposition of David L. Yunich before a Notary Public of the State of New York, held in the offices of the Metropolitan Transportation Authority, 1700 Broadway, New York City, New York, on Monday, July 15, 1974, at 10:45 a.m.

APPEARANCES:

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EDWARD W. SUMMERS, Esq.
For the New York City Transit Authority

ERIC BALBER, Esq.
ELIZABETH DuBOIS, Esq.
Legal Action Center of the City of New York

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Harry Weiner
CSR

and Company. I was then involved as a consultant senior advisor to the investment firm of Drexel, Birnbaum and Company, as well as a consultant for various other businesses, some of which I served on as a director.

Q I take it from your last answer that during the period of time immediately prior to the time you became self-employed, you were with R. H. Macy's and Company?

A Yes, for 33 years.

Q And what position, can you briefly describe what positions you held?

A Well, at the time of my retirement I was Vice Chairman of the Board of R. H. Macys and Company, [illegible]. Before that I was the President [illegible] for about 11 years, and immediately before that I was President of one of the largest divisions in the corporation, Bamburger's in New Jersey. Prior to that I was a Senior Vice President of Macy's [illegible] New York, and prior to that I was Divisional Vice President, and prior to that I was a Vice President of Bamburger's. Prior to that I was the Department Manager of two or three departments in Macy's, having entered their executive training program in 1940.

Rx 66 p. 3

Q Before taking office in the Transit Authority, did you have any prior professional experience with mass transit?

A No professional experience. My only exposure had been as an interested businessman knowing what mass transit meant to the communities that we serve, the business that I was connected with, and also at one time I had an appointment from the Governors of New York, New Jersey and Connecticut to do a special study which took about two years on financing mass transit for the future.

Q I see. Did this study relate to the operations of the Port Authority?

A No. We were studying no particular agency of mass transit, but what we were studying was the importance of mass transportation in this metropolitan region as it affected all agencies as well as private companies that are involved in public mass transportation, trying to get a reading on the financial resources that would be necessary to make this a viable enterprise over the next 15 or 20 years and that emcompassed the Port Authority, all of the agencies or most of the agencies that are involved with the MTA, private bus companies. The area that we looked at extended from Poughkeepsie

to the north, New Haven, to the northeast, all the way down to New Brunswick in New Jersey.

Q Did your study deal at all with the standards that should be used for the selection of transit workers?

A No. I say no, except in the sense that our study did deal with certain matters involving productivity and the effectiveness of transit workers as it related to cost in the various operations.

Q Did you look at all at employees' selection criteria?

A No.

It is my responsibility as the Chief Executive Officer.

Q Previously in this law suit, Mr. Yunich, we served some interrogatories on the Transit Authority, the defendants

this case, and one of the questions we asked, and I am referring to question 31 in Plaintiffs' interrogatory directed to the Transit Authority defendants, gives a detailed description of the Transit Authority's present employment policy respecting former heroin addicts who are presently drug free. We later agreed with Counsel that the word "former heroin addicts" be defined as former heroin users.

In response to that question, it was stated, and I am quoting again: It is the present policy of the Authority, as it was of its predecessors, not to employ or retain in its employment any person who is presently using heroin, or other narcotic drug, or has a history of such usage.

The question went on and referred to a Transit Authority file book. Is that your understanding of the Transit Authority's current policy respecting employment of former heroin users?

A Yes.

I inquired at that point of our officials whether or not they knew what had happened to the Motorman, and the first thought that came to my mind was how old was the Motorman.

It turned out he was about 24 or 25. I asked was there any evidence that he had been a drug user. They didn't know at that point. I asked if there was any evidence that he had been under the influence of drug or was under the influence of alcohol. They didn't know at that point.

Subsequently, it turned out that that was not the case in either instant, neither drugs nor alcohol. I then asked what our policy was with respect to drug users and was told on that platform that morning what our policy was, and I felt somewhat reassured because of my own concern, since we have a deep involvement, as you can understand, with the safety of our passengers. I thought that this policy in fact made sense.

The other exposure that I had was a reading of the testimony of Dr. Ronan, my predecessor, who referred to this policy as well and underscored his own convictions, which I share in terms of the safety requirements of the kinds of activities in which we are engaged.

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Q With whom in the Transit Authority did you discuss this policy since you have taken office?

A With Mr. Scannell, who is the Operating Executive Officer for the Transit Authority, and Mr. Berry. That was the morning of the accident.

Q Did you discuss it with Mr. McLaren or Dr. Lanzetta?

A No. I have had a few other things to do. I was satisfied with the answer that I got there that there was certainly a policy that made sense to me

As you must know, it was indicated in the answer to these interrogatories I read to you, as well as discussions with Mr. Berry and Scannell--the policies are an across-the-board policy that applies to all Transit Authority positions in the Board?

A Yes.

Q Including secretaries, clerks and so forth?

A Yes.

Q Do you believe that this policy makes sense for all positions of employment with the Transit Authority?

A Yes, I do. I have also had a considerable experience with this particular problem as it relates to the retail business. There the thrust of the problem has to do with honesty and the correlation between thievery and drug users. In the course of my experience in retail business, my direct experience at Macy's with the thievery problem started at the point where our shortages used to run less than a half of 1 per cent of our sales. At the time that I left, the Macy history, and, indeed, the history of all retail stores pretty much who are based in large cities like New York, Chicago, San Francisco, was the same. The shortage figure had come to the point where it was 6½ per cent of sales, and we knew from our own hiring practices, from our own employment practices, that this problem directly related in very, very large measure-- not that the shortage was completely the result of internal theft, but a high percentage of the problems of internal theft related to personnel, and the greatest incidence of theft came with the apprehensions that were made of people who subsequently were found to have a history of drug usage, and we knew at the time of the year when business picks up, which was the Christmas period, you had to go out and hire people in great numbers. We

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Yunich, pp. 10-13

Plaintiffs object to this portion insofar as it is submitted for the truth of such propositions as that theft in Macy's was related to drug use and that there is any documentation of such relationship, that his thinking on these matters is shared by other business people, etc., on the grounds that the TA cannot use the deposition of its own chairman as affirmative evidence and on hearsay grounds.

Q Do you believe that this policy makes sense for all positions of employment with the Transit Authority?

A Yes, I do. I have also had a considerable experience with this particular problem as it relates to the retail business. There the thrust of the problem has to do with honesty and the correlation between thievery and drug users. In the course of my experience in retail business, my direct experience at Macy's with the thievery problem started at the point where our shortages used to run less than a half of 1 per cent of our sales. At the time that I left, the Macy history, and, indeed, the history of all retail stores pretty much who are based in large cities like New York, Chicago, San Francisco, was the same. The shortage figure had come to the point where it was 6½ per cent of sales, and we knew from our own hiring practices, from our own employment practices, that this problem directly related in very, very large measure--not that the shortage was completely the result of internal theft, but a high percentage of the problems of internal theft related to personnel, and the greatest incidence of theft came with the apprehensions that were made of people who subsequently were found to have a history of drug usage, and we knew at the time of the year when business picks up, which was the Christmas period, you had to go out and hire people in great numbers. We

have prospective employees showing up at the employment rails, as we call them, we would give them a cursory examination looking for physical indications of drug usage only because of that fact that this had a great bearing on our thievery problem. We knew that in order to get a fix of fifty dollars, they would have to steal about $500. That was documented within our company. It was documented within the N.R.M.A., the National Retail Merchants Association. It was documented in newspaper accounts. Retailers have had a very bad experience as a result of this problem.

So that in answer to your question about an across-the-board policy, the ability to confine this in any one area is most difficult in any operational enterprise, and there are just certain business where honesty is a factor, where safety is a factor, and I feel that this particular problem has to be looked at very, very realistically--what I call realistically.

If we were running a business of reforestration, if we were running a business where we were involved with the kind of task that involved a lot of physical work, where there wasn't a problem of safety that was dependent on that particular individual or where there wasn't a problem of honesty--where an individual could be easily tempted, that would be another

matter. I am involved with the National Alliance of Businessmen who cope with this kind of problem--the New York Coalition. We are very mindful of this, but I must say that I think the kind of thinking that I reflect is very much the thinking that is fairly prevalent among business people who are--or operational people--involved in enterprises that I have just described.

Q Mr. Yunich, you have spoken of the difficulty of containing the problem in the Transit Authority. Specifically, what do you see as the specific problems with employing former drug abusers in clerical and other such positions within the Authority?

A Well, the problem is that there is no way of preventing them from moving into what one might describe as the safe area into some other area where you would bump into this particular situation, and we are in a business that is heavily oriented to the movement of an enormous number of people, and I have never known a situation in business where you can take an employee and say, well, you are hired, but you are going to work in this particular section for the rest of your business life.

You cannot operate a business that way. If you take people on the basis that if they are good they are going to

want to move, and if you want to retain the flexibility, you should be able to move people about, and then you bump into the fact that if they have a history like this and since it hasn't been proven to my satisfaction that all other things are equal, it is just not possible operationally to be able to administer a good personnel practice that way.

Q I take it then from what you are saying that, at least so far as you have stated it, that your primary problem with employing former drug abusers in clerical and other such jobs is that their promotional job mobility possibilities have to be heavily circumscribed?

A Yes. When you say their promotional possibilities, I am a great believer in the system which says a person is going to be only as good as the incentive that you can provide for him to move along, and if you have to take somebody and say, well, for some period of time, however long it is, you are going to have to be confined here, you'll create operationally an unnatural kind of situation that becomes difficult to live with.

Q Was your policy at R. H. Macy adopted after any consultation with outside experts in the field of drug addiction? Did you ever consult such experts respecting its continued implementation?

A I never did, and to the best of my knowledge we have had no consultation with outside experts, as you call them. We have had exchanges of views through organizations like N.R.M.A. as to what policy was followed, through the National Alliance of Businessmen, and so forth, but my experience was that there is pretty uniform thinking on this problem throughout the retail industry.

Q Was your policy based on any study regarding the treatment of ex-addicts?

A No real study other than the hard experience of apprehensions and the correlations of apprehensions to drug users. This then was translated into our hiring policy to be very, very much on the alert. In other words, knowing the high incidence of users among people that showed up in our rails for temporary hiring, before we wasted any time we just put them through a private physician so that the doctor could check very, very quickly whether there were any indications on the arms. If there were, that was the end of it.

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Q Is your thinking about the drug policy that should be in effect at the Transit Authority based on any studies that you have seen respecting the job performance of ex-addicts?

A I have seen no studies. The only thing that I have seen is the little that I have read about this in various national magazines or various trade journals that I read.

Q Do you have any educational training that bears on this particular problem?

A No.

Q You mentioned previously that you participated in a study of mass transit in the years before your appointment as Chairman?

A Yes.

Q Did that study deal at all with the safety problems inherent in operating mass transportation?

A No; purely involved with financing the financial problems, problems of mass transit.

Q You stated that as Chairman of the Transit Authority you are very concerned with the safety of your system and that because you want to insure the integrity and safety of your system you do not believe that you can employ former drug abusers in positions where they might endanger the riding public.

Now, you stated that--I believe this is correct--that one of your reasons for taking this position is that you believe that former drug abusers--rather, that you cannot assure the stability of former drug abusers. When you gave that answer, did you intend us to understand that you were concerned that the former drug abuser, the one who has taken drugs but has ceased taking drugs, might black out, might be an unstable person?

A That is my impression. I am not a medical man. I am not scientifically knowledgeable. My impression is that that could happen.

Q So then it is not just the danger of readdiction or recontinuation of drug use that such a person might suffer; it is also his personality traits that you are concerned with?

A I would have to be convinced again. My impression is that somebody who has once been a user, who once has had the addiction, might be more susceptible to returning to it than somebody who is not. Again, that is my impression in a sort of amateurish way. Back some 35 years ago I was the liquor buyer for Macy's, and at that point in time had occasion to read a great deal about alcoholic problems. I still read about them. My impression was that even after going to Alcoholics Anonymous and taking all kinds of resolutions, somebody who has once been the victim of alcohol is more

apt to return to it. This is what I mean by my impression.

Q I take it from everything that has been said here today, you also don't believe the Authority should hire ex-addicts who are being maintained on methadone, is that correct?

A Ex-addicts who are being maintained on methadone?

Q Yes.

A I certainly do not think they should hire them. Again, I am not a scientific man, but from what I have read on the subject, I am not convinced that that has proven itself. We are in an enterprise here where second guessing is very, very easy. If we were involved in an accident and we said, but this man was on methadone and everything was fine, what do you think the public would say? What do you think your feeling would be if you had the responsibility here? What do you think Neil Armstrong, whose picture is over there, would think when he was sitting up on top of that capsule if he thought that this thing was built by the second lowest bidder, or the lowest bidder rather than by somebody who had checked the system out from A to Izzard.

I am the President of the Boy Scouts. We did a lot of work in the drug field. When I am wearing my Boy Scout hat, I want very, very much to do everything that I can to help that kid get straightened out, to give him a break. When I

am wearing my MTA hat, there just is no room for error. That is the way I feel right now. This is not the kind of enterprise where you experiment in this kind of rehabilitation program or any other kind. That is the sum and substance of the way I feel. If somebody comes along and can prove to me very, very conclusively that the scientific evidence is such that this man is completely cured, completely dependable, I might feel differently.

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THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK
- x

CARL A. BEAZER, et al.,

Plaintiffs,

- against -

NEW YORK CITY TRANSIT AUTHORITY, et al.,

Defendants.

- x

72 Civ. 5307
(T.P.G.)

AMENDED

NOTICE OF APPEAL

NOTICE is hereby given that the defendants New York City Transit Authority, the Manhattan and Bronx Surface Transit Operating Authority, and their members, directors, officers, agents and employees sued herein, hereby appeal to the United States Court of Appeals for the Second Circuit from the Amended Permanent Injunction and Judgment entered in this action on the 28th day of January, 1977.

Dated: February 10, 1977

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